

**PRESENT AND FUTURE COSTS OF DEPARTMENT
OF DEFENSE HEALTH CARE, AND NATIONAL
HEALTH CARE TRENDS IN THE CIVILIAN SEC-
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HEARING
BEFORE THE
SUBCOMMITTEE ON PERSONNEL
OF THE
COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE
ONE HUNDRED NINTH CONGRESS
FIRST SESSION

APRIL 21, 2005

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PRESENT AND FUTURE COSTS OF DEPARTMENT OF DEFENSE HEALTH CARE, AND NATIONAL HEALTH CARE TRENDS IN THE CIVILIAN SECTOR

THURSDAY, APRIL 21, 2005

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:42 p.m. in room SR-232A, Russell Senate Office Building, Senator Lindsey Graham (chairman of the subcommittee) presiding.

Committee members present: Senators Graham and E. Benjamin Nelson.

Other Senators present: Senator Coburn.

Committee staff member present: Leah C. Brewer, nominations and hearings clerk.

Majority staff members present: David M. Morriss, counsel; and Diana G. Tabler, professional staff member.

Minority staff member present: Gerald J. Leeling, minority counsel.

Staff assistants present: Nicholas W. West and Pendred K. Wilson.

Committee members assistants present: Meredith Moseley, assistant to Senator Graham; and Eric Pierce, assistant to Senator E. Benjamin Nelson.

**OPENING STATEMENT OF SENATOR LINDSEY O. GRAHAM,
CHAIRMAN**

Senator GRAHAM. This hearing will come to order. I will defer my opening statement. Would you like to make an opening statement?

Senator BEN NELSON. I'll defer as well, Mr. Chairman.

Senator GRAHAM. We know Senator Coburn's time is valuable, and we appreciate him coming to the committee, Senator Doctor Coburn, I very much appreciate you coming and offering your views on how we can better deliver military health care to our force in a more efficient, responsible manner.

So, Dr. Coburn, thank you for coming.

**STATEMENT OF HON. TOM A. COBURN, A U.S. SENATOR FROM
THE STATE OF OKLAHOMA**

Senator COBURN. Mr. Chairman, and Senator Nelson, thank you for giving me the opportunity to talk about something that's very

dear to my heart, and that's caring for patients. It doesn't matter whether they're in the military or anywhere else.

We're faced with a dilemma in our country. If I may, I'm just going to speak off the cuff here for a minute.

This country is going to spend \$2.3 trillion this year on health care. It's the highest percentage of any nation in the world as far as the percentage of gross domestic product (GDP). We're going to spend 40 percent more per person on health care than anybody else does in the world, and yet we're not healthier. When we talk about care for our veterans and care for our military, this same thing applies. We're at 8 percent of the Pentagon's cost for care for our military today. It's going to go to 10, and it's probably going to go higher, if in fact, we don't start addressing health care in general in this country, and specifically the care for those people who serve our country.

I would put forward to you, the people who deserve the best care in this country are our military and our veterans—not the worst care. By that, I'm not saying that they have received the worst care. But I'm convinced that we need to have a new paradigm, in terms of how we look at health care.

The first question we need to ask ourselves is, how do we do this better? Spending this much money, can't we do it better? There's a lot of areas in which we can do better.

In preparing for this testimony, I asked the military to give us what the percentage was paid on TRICARE in terms of profits to the Health Maintenance Organizations (HMOs). They don't know that answer, and I understand that they may not know that answer, but I think that's an important thing because, when you look at the \$2.3 trillion that we're spending, about \$300 billion of it is pure profit that goes into insurance, managed care, and everything else. Out of that \$2.3 trillion, \$700 billion never goes to help anybody get well. That's a tragedy in this country, when we have 40 million Americans that don't have any health insurance, their coverage is coming to the emergency room (ER), which is burdening our ERs. We have to do better.

I want to talk about TRICARE a little bit. I didn't qualify for TRICARE, nobody in Muskogee, Oklahoma qualified for TRICARE, because the HMO only allowed people in Tulsa to participate. So, if you were a military family—I delivered the children of many military families—you had to drive 60 miles to get TRICARE.

Senator GRAHAM. Why was that?

Senator COBURN. Because the HMO didn't decide they wanted to have any more people in their network, even though my group and my partners were well-qualified. What happens is, the Services break down—for health care to be available, it has to be accessible, and to say you have to drive a distance to be able to attend that is wrong. That doesn't mean that the people running TRICARE made a mistake, it means that the system under which we're operating, where they're trying and they're doing the best they can to save dollars is wrong.

Take Austin Heart Hospital out in Killeen, Texas, and in Temple, Texas you have Scott White. At Scott White, less than a third of the doctors are qualified under TRICARE. Scott White is one of the best hospitals in the southwest area, and yet, when somebody in

the military needs help, Austin Heart Hospital takes care of them because they're hooked up to TRICARE, but in Temple, Texas, Scott White didn't for those particular reasons. So, here you have a specialty hospital, which pays taxes on their investment and everything else, and here you have a government-subsidized hospital with no taxes and no profit, and they don't, as a general rule, accept TRICARE. I'm not going after them, I'm just using this as an example to say that we have a health care system that's broken, and it's broken for our military, and it's broken for everybody else. By focusing on it, I think there's probably five or six things you should hear from me.

I think there are five things that have to happen in this country before we're going to fix the problems for military health care and everyone else, and I don't believe you can fix the problems for military health care or veteran's health care until you address these five issues.

There isn't any emphasis on prevention in this country. Grandma's right—an ounce of prevention is worth a pound of cure, and let me just give you two examples.

We now know, through repeated studies, that children who are exposed to high fructose corn syrup that comes from Nebraska and Oklahoma, have twice the lifetime risk of diabetes as children who ate the same things sweetened with sugar beet or cane sugar. Now, if that's true, why wouldn't we immediately make sure everyone in the country knew that? Where's the mechanism for them to know that? Where's the prevention that is out there to teach the American people what they need to know about making healthy lifestyle choices? Where's the leadership? What I'm proposing to you is we need to have leadership on prevention in this country.

The second example I will give you is this: There are now good studies that say you can cut your risk of colon cancer in half if you're an adult, which is 189,000 cases a year. It's the second leading cause of death in this country from cancer. We can cut that in half by taking three over-the-counter medicines: Caltrate D, folic acid, and an aspirin—but yet how many people in America know that? That is a legitimate role for the Federal Government under which it's totally failing in terms of prevention today.

Prevention is undermined also because we don't pay for prevention care when we go to practitioners or providers. I don't care whether it's a nurse practitioner or a doctor, there's no recognition in the current procedural terminology (CPT) codes for true prevention, counseling and treatment, and that's a key part of any future solution to health care. If you look at the numbers in 2060, half of the dollars that are going to be spent in Medicare are going to be for diabetes alone, so if we could cut the rate of diabetes in half, you could cut half the cost of Medicare in 2060. We have a \$43 trillion unfunded liability in Medicare alone. That's going to balloon up every year as our population ages, and we don't do things on the basis of prevention.

The second thing we need to do is we need to improve the quality of care by practitioners. The way we do that is to reward good behavior, and punish bad behavior economically. You do that through best practices, and Information Rx. You put the patient in the game, you make them participate in knowledge of what is good for

them and what is not good for them. The way you do that is by cutting, if they'll participate in the Information Rx stuff, they need to know to lessen the risk, then you make it less costly for them. If the doctor participates on the basis of best practices, you make it more rewarding.

We don't need a government mandate that says you have to do this, that, and the other. What we need is to use that common thing—greed can resolve technological difficulties and natural human behavior, incentivizing to do the right thing, and we don't have that now.

The benefit from that will be better care, less cost, more satisfied providers, and more satisfied patients. Where it has been done in two trials right now, the cost of health care in the first year alone went down 32 percent. The outcomes were far improved, the practitioner satisfaction was higher, and the patient satisfaction was higher.

The third thing we need to do is to have competition at every level in medicine, and that means every stakeholder has to give. That means you need to be able to look at a doctor and say, "Is he good, or isn't he?" That means doctors need to be weighted, that means the poor doctors need to get out, the good doctors need to get better, and they need to get rewarded for being better, and we put them into the game for improving quality. We know all of that information now, the doctors are worried about, "How do you make that, when I have outliers or patients that are complicated?" You only compare them to other people that have patients that are complicated, but the fact is, the medical profession is going to have to be rated and charged by community, so they can decide who they want to go to. That's fair, it happens in every other area of life, so there is no problem with that, and that will spur better competition, higher level of excellence and performance, and less waste.

The fourth thing we need to do is to have a truly competitive drug market. We don't have that today, but that's a topic for another hearing. But the fact is, Americans subsidize the drugs for the rest of the world and they subsidize the vast majority of the research for the rest of the world. The administration does not do a good job of protecting their intellectual patents and their intellectual property, and we need to do that. We also need to demand that there are competitive markets here, and I can give you plenty of proof that there's not if I get the opportunity.

Finally you have to reconnect the patient into the game by making them have to make a discretionary decision on whether or not they're going to utilize the health care system. You cannot do that unless you incentivize preventative care at the same time, which means you have to create a basis that everybody gets a comprehensive exam on a timely basis, so they will not ignore prevention and care, and risk screening. You can incentivize, and I'll give you a great example. In my office, as soon as medical savings accounts were set up, we created medical savings accounts, the vast majority of the employees that were in my office have \$3,000 or \$4,000 in their medical savings account, above the level of their deductible. In other words, even if they had a catastrophic event, they still have \$3,000 or \$4,000 left in it, which gives them discretion on where to spend it. Do they want to spend it on eyeglasses for their

kid, or do they want to get braces on their child? Or do they want to have a test that maybe they don't need? The other thing that happens is they don't just take the price at which it's offered, they say, "Hey, I'm paying cash for this, what's your best price?"

I can give you examples of how, when you put the market economy into it, a \$25,000 procedure just a month ago on a patient in my office, we got done for \$2,800 by him negotiating to pay cash. You can see the cost savings are out there. Remember, we have a lot of facilities and we're not utilizing them. If you start utilizing this capital investment in a way that tonight, running magnetic resonance imaging (MRI) scans at night, doing ultrasounds at night, where we take this capital investment, but we're not using it at other periods of time, we're going to save tremendous amounts of money.

I believe that we ought to have competition in the mix, and I believe that we ought to allow the consumer to drive that, and that also goes for the military consumer. I will go back to what I said, that they ought to have the best care there is, but the way to get that is not to throw money at it and not to micromanage it like a Soviet-style bureaucracy, but let what we use in the rest of the country to allocate scarce resources, do the same thing in the military. We can do it. You can't just do it in the military, we have to do it everywhere because we're not going to have the funds for the military—whether it's for health care or future defense of our country—if we don't fix health care anyway. So, we have to look at this as not just fixing military health care, we have to look at it as fixing health care in total.

The last thing that I would tell you if I was in the military—and I served my country—whether I was a veteran today or an Active-Duty military or retiree, if you gave me a card and told me to go where I want, and let me negotiate it, you would be giving me the service back that I gave my country. You can do that in a competitive framework and probably save money, if you use Medicare reimbursement as the rate, and I'll tell you why. Because most of us want to care for the military and their families, we recognize their contribution to our own freedom, and our own benefit that we derive from that contribution. I would tell you that if you set that up tomorrow, and you ran all the numbers that they run on TRICARE today and ran it through at Medicare rates, you would save several billion dollars in health care costs for the military, and you would get as good, or better, care.

With that, I'll answer any questions you might have.

Senator GRAHAM. Thank you, that was very compelling, Senator Coburn. Let's say that we had this card, and you reimbursed at Medicare rates, what kind of availability problem, if any, would you have among physicians?

Senator COBURN. I don't think so, if they're military. Again, I think it goes back to the idea that we have an obligation to serve. Run a test on it, put it into an area, say, "Here's your card, you're eligible, here's the deal, we've made a commitment to cover you, let's see what it will save."

Senator GRAHAM. What is your view from a physician's point of view about TRICARE, in terms of its efficiency? Is it something

that you would like? What is your view of the physician community's view of TRICARE?

Senator COBURN. I don't think it's any different than any other HMO program we see. We see micromanagement that costs time in the doctor's office, it interferes with care, and that is not TRICARE, that's all of them. The point is, we will never have enough resources to manage it tightly enough, and remember you're dealing with people that can find the holes. They're not really dummies, or they wouldn't have made it through medical school and residency. They're going to find the holes. They're going to find another hole, you're going to plug a hole, they're going to find another hole, and you're going to plug another hole. All of that is money that is spent that should be going to help people who don't have health care today. They're not bad. The other thing is, management of health care systems is profit-driven for the managers, but not for anybody else. They make more money if they spend less money. Is that what we really want?

Senator GRAHAM. Senator Nelson?

Senator BEN NELSON. Well, thank you, Dr. Coburn. Senator Coburn, as you look at the whole system, what do you think we can do here—the administration has selected Social Security, I don't have a quarrel with that—but what can we do without this being driven from the top down, as well as from the legislative side as well? We can't take the entire health care system on just in this committee. Do you have any thoughts about how we might address all of it?

Senator COBURN. I'm presently working on a total health care reform bill for the whole country that is based on the principles of quality, accessibility, availability, competition, and accountability. But competition is the key. Competition is a very controversial subject up here today. Take competition of specialty hospital versus the non-specialty hospitals for example. That's a big fight up here right now. It's a big fight because you have tax paying specialty hospitals who pay real estate taxes and income taxes, against subsidized hospitals who don't want them, but what's the outcome? The outcome is, the quality is far superior, the cost is far less, and the patient satisfaction is far superior.

So, here we have competition, and what's happened, where you see a specialty hospital in town, where you don't, where they're competing, the costs aren't coming down at the government-subsidized hospital, because they have to compete. The quality starts going up. The outcomes start improving. Why? Because they have to compete for the patients. So, I believe, we wipe the slate clean, we sit down and every stakeholder has to talk about how they get it. The large corporations in this country are spending a ton of money for health care. They're a big stakeholder, they want to see these costs go down. These two towns where we're running the system now, a 30-percent reduction in the cost with better care, without having anything to do with drug prices and without having anything to do with tort system. There is no impact on those two—and they've dropped the cost by a third. That's in Oklahoma, and the same system is being replicated in a couple of places in Virginia. If it will work there, it will work anywhere. But it's based on the incentive of, "How do I get paid more?"

The whole physician complex is falling apart in this country. This year at the University of Maryland, I believe, they have no one going into obstetrics/gynecology (OB/GYN) for their residencies. Johns Hopkins is half full, and that's true across the country. Only 60 percent of the slots were filled in obstetrics in this country. In other high risk areas, there's no one going into it. Doctors are retiring at 50 years of age because they're through fighting the system, and it's not just liability, it's not just the tort system, they're tired of fighting with the management companies that tell them, answering the phone call from somebody on a computer screen whose never put their hand on a patient, saying "Here's what you have to do."

That is what we're approaching now, trying to control the costs. We're trying to control the costs, but doctors aren't great. But we have real problems in terms of continuing medical education, but if you tie quality outcomes to payment and best practices, guess what's going to happen? You're going to have people enjoying their work again, not retiring, spending more time with the patient. The average time in the private sector, when you walk into a doctor's office before you're interrupted by the doctor is 7.9 seconds. Why? Because they're feeling—the only thing a doctor has is time—that's the only thing they have to sell. As their revenues have gone down and the costs have gone up, what they're trying to do is cram in more patients, which is going to lead to poorer quality. The worst thing it does is to undermine the art of medicine. People, a lot of times, don't understand what that is. Medicine is 60 percent science and 40 percent art, and anyone who has been trained over the last 50 years in this country up to about 1990 knows that.

Now, we're training a different type of doctor today, who does tests, and it's a clinical situation rather than a total care type situation. Look the adage in medicine, "If you'll spend the time with your patients, your patients will tell you what's wrong with them." We're not spending any time with our patients. That is one of the reasons that malpractice errors are up. They're incentivizing doctors not to spend time with their patients, rather than to spend time and listen and ask.

Quality is going to go down, and it's going to continue to decline, so we're losing our most experienced doctors that are leaving, retiring, or quitting. We're having people who come in now that are committed to a 40-hour workweek, rather than taking care of folks, and we're seeing that this whole thing is going to implode. So I believe we have to wipe the slate clean for the stakeholders in the room, and rewrite the look of this and use what we have done to allocate scarce resources in the past in this country, which is competitive modeling.

Senator GRAHAM. There's a lot to think about. Well done, we really appreciate it, and we'll try to incorporate some of your ideas to improve health care for veterans and our Active-Duty, Guard, and Reserve people.

Senator COBURN. Give them real choice based on quality.

Senator GRAHAM. Thank you very much, Tom. Dr. Chu?

Thank you for your attendance today, both of you. Senator Nelson, do you have a statement you would like to make?

Senator BEN NELSON. First, Mr. Chairman, I want to thank you for holding the hearing. Obviously, health care is vital to all Americans and certainly very vital to our military and to our retirees. I appreciate the fact that you're holding this hearing. We want to make sure that we not only have it available, but we have the best health care available. We just heard Senator Coburn give us a primer on what we need to do. I'm looking forward to Dr. Chu and Dr. Winkenwerder and their responses to some of what we have been told, but also laying out the health care for veterans and for our Active-Duty, Guard, and Reserve units at the present time. So thank you very much, Mr. Chairman, thank you gentlemen.

Senator GRAHAM. Thank you, Senator. I will defer any comments, and look forward to hearing from both of you.

STATEMENT OF HON. DAVID S.C. CHU, UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS; ACCOMPANIED BY HON. WILLIAM WINKENWERDER, JR., M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. CHU. Thank you, Mr. Chairman and Senator Nelson. It's a privilege to be here this afternoon, to be joined by my colleague, Dr. Winkenwerder, Assistant Secretary for Health Affairs. We have a joint statement that I hope you will be willing to accept for the record. Let me, if I might, offer a few introductory comments, and then turn to Dr. Winkenwerder to talk specifically about the cost of the current program, which is the focus of your request, and our forecast about the likely future cost of the current program.

As you appreciate, the Defense Health Program is the vehicle by which Congress and the country provides the financial resources to the military health system, and that system in turn has two significant responsibilities. First, to care for those who wear the country's uniform, particularly when they are deployed in missions supporting our national interest, currently, and especially in the Central Command area of operations; and second, that same system provides a benefit. It provides medical care not only to the uniformed person, but also to his or her family and importantly, to those who have retired from military service under the TRICARE program.

I think you are familiar with how we have transformed medicine for deployed forces. In the past, we used to take the medical care system forward and treat patients in theater. We have completely reinvented that system, with the operations in Afghanistan and Iraq, in which the emphasis now is on stabilizing the patient there, and bringing him or her promptly back to a safe haven where he or she can receive the best possible definitive care. I think their testimony endorses that choice. It allows—among other things—the family to be at their bedside during the recovery period which, as we all appreciate, is very important to the eventual healing.

We recognize that the personnel system for those that return from theater needs to be at the same high level of functioning. That is one of the reasons we have opened this joint operation center for the severely wounded, as a capstone of the individual service programs to deal with the personnel needs of the injured service man and woman.

Let me spend a few minutes speaking to the benefit mission, if I might, of the military health system. As you appreciate, this is a benefit that grew up over the decades. If you look back to the second World War, just before that war and the period immediately afterwards, it was a benefit provided de facto, often without statutory foundation, all on a space-available basis. Indeed it was the fact that space was not available to all dependents of Active-Duty servicemembers—at least as I understand the history—that led Congress in 1956 to enact the statute that authorized the CHAMPUS program, or a third party payer type classic insurance program in the Department. That evolved over the years with legislation. In the mid-1980s, Congress authorized what is now the TRICARE program, which provides three different levels of benefit, depending upon the family's, or retiree household's choice.

I'm impressed at how far TRICARE has come. I had the privilege of serving this Department just before it was inaugurated. I remember the early days of the program. In the early days, the program was not well-regarded by our beneficiary population. Only a third—less than a third—of the population was willing to rate it 8 or higher in quality, on a scale of 1 to 10, with 1 low and 10 high.

Today that number is well over half of our beneficiaries—so they rate it. In fact, we're being paid, in an interesting way, an enormous compliment—others seek to join this program: Congress has authorized that through TRICARE for Life for those retirees over 65 years of age and otherwise restricted to Medicare under previous statute. Now we have the TRICARE Reserve Select Program, which importantly is due to the leadership of members of this committee, and forged, really by this committee in last year's authorization conference, which we have just started, and we're looking forward to bringing to fruition.

In short, we have come a long way. At the same time, that progress has brought with it substantial cost. There are a variety of factors that drive this cost, and Dr. Winkenwerder is going to touch on those factors, but in the end—in the end, the most important factor affecting the cost of medical care in the Department of Defense (DOD) is what we decide are the benefit parameters for our military service personnel and our retired military personnel.

Thank you, Mr. Chairman.

Bill.

Dr. WINKENWERDER. Thank you, David. Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to discuss the Military Health System.

We have submitted broader comments for the record, but what I would like to do is take time here today to speak specifically to the rising cost and the expenditure, and those attendant issues. This issue is of vital importance to Congress, as I think Senator Coburn so eloquently said. It's also of importance to our health care beneficiaries, to the DOD, and to the future of our Nation.

I'm referring to the rising cost of our health care program, and the trends that we see taking shape in military medicine, and therefore the sustainability of our military health benefit.

As Senator Coburn just said, increased health costs are not unique to the military health system. It's a national concern and we're struggling with it. I commend you for taking this on, because

it's an issue that some people do not want to take on. For the Military Health System, our goal is to provide world-class health care for those who have served and continue to serve our country. Let me just say, the DOD is firmly committed to protecting the health of all servicemembers, and all of our beneficiaries, now numbering more than 9 million. We are determined that we will always have an outstanding health benefit, and one that provides outstanding quality care.

Expenses for the Defense Health Program are growing rapidly, and some have noted and has been in the press recently, our program has essentially doubled in size in just the past 4 years, from about 18 billion, to 36 billion this year. It now appears that our total budget is likely, if the current trends continue—and we don't see any reason, pending any change that they wouldn't continue—that this will exceed \$50 billion within 5 years. If these current trends continue, we estimate that by fiscal year 2010, approximately 70 percent of our health budget will be spent for retiree health care.

The facts show that our expansion of health benefits, such as those for our senior retirees underlies this growth, and that growth could put today's operations and sustainment at risk. Expansion of the benefit has also led to an increase in pharmacy costs, our total pharmacy program has increased 500 percent since 2001, approaching \$6 billion this year. We are now implementing the new TRICARE Reserve Select Program for guardsmen, reservists, and their families. We believe this is a needed benefit that properly recognizes those who have served, who may require support during their transition to and from Active service, and we urge Congress to allow us to implement this new benefit before making further new changes.

I want you to know the Department has acted to better manage limited resources, and I'll talk about just a couple of the things we've done. We are implementing performance-based budgets and prospective payment, we are improving our pharmacy program with the uniform formulary, and using Federal pricing for our retail pharmacy network, as we have for our mail-order and military treatment facility outlets. Our new TRICARE contracts, in fact, address Senator Coburn's comments, are designed to leverage private sector methods to control purchased health care costs.

Still, management actions alone, even dramatic ones in my judgment, will not stem the rapid growth in our spending, and that is because benefit expansion and rising utilization are the driving forces in sending these costs upward. Our benefit structure has not kept pace with changes in the private sector, or in the industry, and enrollment fees and cost shares have not increased in 10 years. Cost differences between TRICARE and employer-based private plans, or even Federal employee plans, which are excellent plans, those differences have grown. For example, the Federal employees' cost during the period of 1999 to 2004, that 5-year period, have increased 57 percent, for example, for Kaiser Permanente in the mid-Atlantic, in this local region, and 87 percent for Blue Cross Standard. While those same cost shares have remained absolutely unchanged for TRICARE. This has persuaded a growing number of our beneficiaries to drop their private coverage, and to fully rely

upon TRICARE. The low out-of-pocket costs and outstanding benefits are driving, I believe, that nearly all of our retirees will rely on TRICARE, rather than their employer-based plans, in just a few years.

Simply put, we face a tremendous challenge with a benefit design that does not always reward efficiencies of care, and that is increasingly out of step with employer plans. Many in the private sector have turned to disease management and changes in benefit design, and while others have turned to Health Savings Accounts (HSA), or consider Health Savings Plans that reward individuals who manage their spending, and we too believe that we must find a solution that will enable us to sustain a fiscally sound health program for all of our beneficiaries over the long term.

We will continue to benchmark our program with the private sector, to ensure an optimal balance between innovation and the need to sustain ongoing commitments to our beneficiaries. We will work closely with the leadership of the DOD and with you, Mr. Chairman, and with the committee as we seek viable options to contain costs, while ensuring an outstanding health benefit.

Let me just close in saying, the mission of the U.S. military has always been to defend our country and the freedoms in place by our Nation. Many servicemembers have devoted their entire careers to serving our Nation, 20 to 30 years or more, some have served bravely in combat—we can never thank them enough for their dedicated service. What we can do is offer the best medical care possible to these patriots and to their families. We've made a commitment to provide them exceptional care while on Active Duty, and in retirement, just as they made the promise to defend our freedoms. We will deliver.

Mr. Chairman, the military health system has a great mission, it is a precious national asset, and I'm honored with the opportunity to lead it, and with that I say thank you, and we would be glad to answer your questions.

[The joint prepared statement of Dr. Chu and Dr. Winkenwerder follows:]

JOINT PREPARED STATEMENT BY HON. DAVID S.C. CHU AND DR. WILLIAM
WINKENWERDER

Mr. Chairman, distinguished members of this subcommittee, thank you for the opportunity to discuss the Military Health System (MHS). Today, the Armed Forces of the United States have more than 275,000 service men and women deployed around the world in support of our national military commitments, including those serving in Afghanistan and Iraq. The Department of Defense (DOD) is firmly committed to protecting the health of these and all servicemembers, before, during and after their deployment and to our other health care beneficiaries, who now number more than 9 million.

When we assumed our positions in the DOD, we faced the tragic events of September 11, and our Nation was about to embark on the military campaign in Afghanistan against the Taliban and al Qaeda. Then, within a very short period, our country suffered suspected internal anthrax attacks against Members of Congress, the media and others. From those events, we found that the country had a very limited supply of anthrax and smallpox vaccine, and limited means to detect a domestic attack by such bioweapons. Also during that period following September 11, there was neither a Department of Homeland Security (DHS) nor a Northern Command, and almost no concept of "interagency" collaboration. Efforts to improve intelligence gathering and analysis had barely begun.

Internationally, Saddam Hussein and his brutal sons, other Baathist henchmen, and terrorists were relatively free to come and go as they pleased, and to carry out attacks on innocent people in the Middle East and elsewhere around the world.

In short, the world had arrived at a very dangerous point in time.

In many respects during that period, we were just beginning to understand the scope and nature of our new enemy. In just a little more than 3 years, the United States has met several stern tests—tests of will, conviction and sacrifice. We have come a long way. Today, there are many signs of success and hope. Clearly, we are seeing the beginnings of a new and perhaps hopeful future for the Middle East. As an example of this change, we have seen Palestinians democratically elect a leader for Palestine who is now working with the Israelis; a democratically elected government in Afghanistan that continues its path of rebuilding a bright future for its citizens; and, for the first time in more than 50 years, more than 8 million Iraqi citizens, in defiance of insurgents, recently voted to begin the developmental process of creating an elected government. We are also beginning to see positive changes in countries such as Lebanon, Pakistan, Libya, and Saudi Arabia. Terrorists are on the run and finding fewer and fewer places to hide. In Afghanistan and Iraq, and elsewhere, the United States has killed or captured thousands of terrorists and we continue to face a vicious and malignant insurgency—a mix of old regime loyalists and new fanatics. We do not stand alone, but are engaged with many other countries in this international fight. Although Iraq is still a battleground, it continues its rebuilding efforts, not only the result of the war, but also to repair more than 30 years of designed neglect by Saddam Hussein.

Not long ago, Dr. Winkenwerder had the opportunity to visit servicemembers and our medical staffs who are so hard at work in Afghanistan, and to compare the conditions found there now to what he observed there just 2 years ago. He reported that morale was high and the performance of our people—superior. We know you too salute the extraordinary efforts of these honorable troops who truly are serving our Nation so well. During his time in Afghanistan, Dr. Winkenwerder also had the opportunity to meet with President Hamid Karzai. Without question, he found him an outstanding leader who, with our help and the help of other allies, continues unparalleled progress toward creating a better life for his country and its citizens.

Throughout all of these world events since September 11, 2001, the leadership of the U.S. military has had a clear and consistent message to our men and women in uniform—we will take care of you because you are facing dangers and hardships daily as you go about the task of carrying out our Government's missions, protecting Americans, and advancing the cause of freedom and democracy in the world. Throughout the DOD, the men and women of the Military Health System contribute every day to the care and comfort of our servicemembers. These medical professionals, from the doctors and scientists to nurses, technicians and medics work around the clock keeping America's military fit, safe, healthy, and protected so that it can carry out its mission—a mission that, perhaps, has never before been as complex, challenging, or far-reaching as we find today. At the same time, these medical professionals also are defining, preparing and participating with others at the national level in improving the Nation's medical emergency preparedness should the unthinkable happen. As some have put it, we are the "go-to team" on the other end of that 911 phone call when local, State, or other Federal assets are overwhelmed.

MILITARY HEALTH SYSTEM FUNDING

Before describing our military health activities, we would like to address our Defense health funding situation and highlight initiatives to manage costs. Defense Health Program (DHP) costs continue to rise due to increased utilization of the MHS. The fiscal year 2006 DHP funding request is \$19.8 billion for Operation and Maintenance (O&M), Procurement and Research, Development, and Test and Evaluation Appropriations to finance the MHS mission. We project total military health spending to pay for all health-related costs including personnel expenses, and retiree health costs, to be \$33 billion for fiscal year 2006. To fund this growth, the O&M Appropriation submission is 11 percent more than the fiscal year 2005 appropriated amount. This funding growth is the result of benefit changes for our beneficiaries, to include the Reserve components, increased health care costs in the private sector, and the decision of MHS-eligible beneficiaries, mainly our retirees, to drop private insurance coverage and rely upon TRICARE.

The Department has taken several actions to better manage resources. The MHS is implementing performance-based budgeting, focusing on the value of services delivered rather than using old cost reimbursement methods. We are introducing an integrated pharmacy benefits program that uses a standardized formulary that is clinically and fiscally sound. Federal pricing of pharmaceuticals in the TRICARE re-

tail pharmacy program will help significantly to contain costs. Quality management programs continue to ensure that care provided is clinically appropriate and within prescribed standards.

Performance-Based Budgeting

With this budgeting approach, we intend to base Military Treatment Facility (MTF) budgets on workload output such as hospital admissions, prescriptions filled and clinic visits, rather than on historical resource levels such as number of staff employed, supply costs, and other materials. We are in the first year of a planned 4 year transition to this new prospective payment system which will provide incentives and financial rewards for efficient management.

Integrated Pharmacy Benefits Program

The redesign of our pharmacy programs into a single, integrated program, beginning in June 2004, simplifies and allows us to more effectively manage this \$5.5 billion program. We are standardizing formulary management, achieving uniform access to all medications, enhancing portability, and involving beneficiaries in formulary decisionmaking. We will promote the use of more cost-effective products and points of service. Application of Federal pricing for the retail pharmacy benefit will allow the DOD to obtain manufacturer refunds for medications obtained through our broad retail network. We currently use Federal pricing for mail order and MTF pharmacy services.

Quality Management Programs

We continue to improve the quality of care delivered throughout the MHS, employing sound management practices and metrics to ensure appropriateness of care. We monitor the health of our population using Healthy People 2010 goals as a benchmark, and we measure the quality of care provided using Joint Commission on Accreditation of Health Care Organizations Oryx indicators.

Our new health care contracts use best-practice principles to improve beneficiary satisfaction and control private sector costs. Civilian contract partners must manage enrollee health care and can control their costs by referring more care to MTFs. In concert with these new contracts, and the implementation of the prospective payment system, we need the flexibility to flow funds between MTFs and the private sector. Currently, MTF revised financing funds are in the private sector budget activity group. Restricting the movement of DHP funds does not allow MTFs to use these revised financing funds to increase productivity and workload without prior-approval reprogramming. We appreciate the congressional intent to protect direct care funding. However, the current restrictions on funding adversely affect MTFs as well as care in the private sector. We urge you to allow the MHS to manage our funds as an integrated system. Funds must be allowed to flow on a timely basis to where care is delivered. We seek your help in restoring this much needed management flexibility.

BATTLEFIELD MEDICINE SUCCESS

Today, military medicine is saving hundreds of lives that previously would have been lost on the battlefield. Better training, advanced equipment, and talented and dedicated soldiers, sailors, airmen, and marines also contribute to this success. Fewer than 2 percent of wounded servicemembers who make it to a source of medical care die of their wounds. This is the lowest figure in the history of warfare. On its own, this milestone is a remarkable accomplishment. It was achieved due to the proficiency and professionalism of our medical personnel who have advanced battlefield medicine and medical transportation to new levels of capability. Our people are also doing an extraordinary job preventing illnesses and maintaining health. This progress is mirrored in our disease and non-battle injury rates that are only about 4 percent in Iraq—which also are the lowest in military history; this 4 percent is about 50 percent less than that experienced during the 1991 Gulf War.

Despite these historically low rates, the DOD continues to seek even better ways to care for our servicemembers. We have new programs and initiatives, for example, to take care of the severely wounded. While servicemembers are surviving injuries in record numbers, we now must treat and care for those severely injured as we help them return to productive lives. Among these new programs are the Assistive Technology Centers for amputees at Walter Reed and Brooke Army Medical Centers, and others such as the Army's Disabled Soldier Support System (DS³). General Bill Fox, Commander of Brooke Army Medical Center, the Army Vice Chief of Staff, and the Sergeant Major of the Army, opened the Brooke Amputee Care Center this January. The aim of this Care Center is to return patients to their "highest possible level of activity." It does so by incorporating a full range of amputee care at one

site, including services for orthopedics, rehabilitation, occupational therapy, physical therapy and prosthetics. It also offers these servicemembers quick access to social work and Department of Veterans' Affairs (VA) counselors, when needed. The Walter Reed and Brooke centers also provide an opportunity for additional research in rehabilitation and prosthetic design. Walter Reed Army Medical Center, the Department's first amputee care center, has cared for more than 200 troops from operations in Iraq and Afghanistan. The combined effort of the Centers' staffs is remarkable and it's just amazing to see these health professionals attain their goals of returning seriously injured servicemembers to a "tactical level of athleticism," including such activities as running track, bicycling, wall-climbing, and rappelling. It is also satisfying to see the optimism and "true grit" of our injured and wounded warfighters as they meet the challenges of their particular situation.

IMPROVING MENTAL HEALTH SERVICES

During the past decade, we have learned valuable lessons. Among these are identifying and gaining a better understanding of the health effects of deployments and operations; we are happy to report that the DOD has made great progress in these important areas. To date in the current conflict, servicemembers have completed more than 1 million pre- and post-deployment health assessments. Nearly 90 percent of this information is collected and transmitted to the United States electronically. This information helps us to improve follow-up care and treatment, ensures our people get the care they need, and assists the Department with its medical planning efforts.

War is always a difficult undertaking. Stress, uncertainty, separation from loved ones, daily risk of death or bodily harm and, frankly, witnessing of horrible events—take a mental toll on many of our servicemembers. These mental health issues strike even our strongest and most brave. This is a challenge we must meet—and we believe we are doing so in a concerned, straightforward and timely fashion. The DOD today has a better understanding than ever before of the effects of combat and other rigors of war on our servicemembers. In recent years, the military services began deploying combat stress control teams at the unit level and using them far forward in combat zones. These specialized teams do a fantastic job; they are making a real difference. They are part of the forward edge of our health care continuum, which extends back to include post-deployment health assessments, family support services, and reintegration into home life.

Another lesson that we've learned is that the period of highest risk for mental and family readjustment problems may be weeks after someone returns home. With this in mind and in consideration of the potential for physical health issues to arise once servicemembers return, we recently directed an additional post-deployment health assessment—a follow-up program that expands upon our previous efforts. We recognize that no one who goes to war remains unchanged. However, not everyone is affected in the same way and not everyone has mental health or readjustment issues. But, some, a minority, do have health issues, and their health is our concern. This new effort will include a short interview questionnaire to be filled out by all servicemembers—including reservists and guardsmen, 3 to 6 months after they have returned home. Once they complete the questionnaire, servicemembers may be referred to a health care provider to discuss issues of concern and obtain needed assistance. The intent of this program is to help determine the health status or personal situation of the servicemember with a focus on discovering any readjustment issues or problems. To get to the heart of issues, counselors will ask such questions as: "How are you doing?" "How is your family?" If things are not well, we want our servicemembers to know that help is available. We believe that with this new disciplined and caring process, we can reach those who may need help and make a real difference where it is needed. There remains a common, general public perception in our country—a stigma—regarding the need for mental health services. We believe that through this new, follow-on reassessment tool, we reduce this "stigma" as an issue or barrier to needed care.

MILITARY VACCINE PROGRAM

In this war on terrorism, the Department has had programs to protect our servicemembers against the threat of Smallpox and Anthrax, which we believe to be two potential bioterrorism weapons of concern. To date, we have vaccinated more than 1.3 million DOD members against Anthrax and over 700,000 for Smallpox. These programs have an unparalleled safety record and are setting the standard for others in the civilian sector. Our Anthrax program currently is on hold, the result of a Federal district court judgment last October. We worked with the Department of Health and Human Services, the Food and Drug Administration (FDA), and the

Court to restart this important program, and I am optimistic that shortly we will return to providing our servicemembers this vital protection. Our servicemembers deserve the protection the Anthrax vaccine provides.

BIO-THREATS

We want you and the world to know that the Department is at the forefront of science, research and development for medical countermeasures to biological threats, and for sensors, detectors and surveillance systems to protect all of us from a chemical or biological or radio-nuclear attack. For example, just 3 years ago, the Pentagon had a research idea—an environmental detection system to detect airborne pathogens. Today, this vital protection system, known as Biowatch, has been installed in more than 30 cities throughout the Nation, including Washington DC. Additionally, the President's Project BioShield program provides nearly \$6 billion to develop an effective stockpile of protective vaccines and drugs. Similarly, we played a key role in developing the "National Interagency Biodefense Campus" (NIBC) at Fort Detrick, Maryland, to accelerate research on medical countermeasures. We are most pleased to recognize the outstanding leadership of Fort Detrick's Major General Martinez-Lopez in developing the NIBC. This project also involves close coordination with the Departments of Homeland Security and Health and Human Services and other Federal agencies.

Finally, on the research front, the Department continues its work on other vaccines and measures that have great promise toward effectively combating such diseases as HIV/AIDS, tuberculosis and malaria. Not only do these efforts hold great potential with significant benefits to our servicemembers, but they can help in worldwide humanitarian efforts as well.

HUMANITARIAN OPERATIONS

Natural disasters and humanitarian issues are constantly a challenge to the world. The Department's medical assets often provide unique capabilities not found elsewhere. The recent tsunami in South Asia was unprecedented in its devastation. A worldwide response developed very quickly to support those affected by that incredible disaster. In cooperation with many other nations and multi-national groups, the U.S. has been a major contributor to the relief efforts. Once again, the Department and the MHS demonstrated substantial and unique capabilities of support for humanitarian operations; we helped make a major difference to the people of South Asia. Dr. Winkenwerder had the opportunity to observe part of DOD's effort when he recently visited Indonesia and our crew aboard the U.S.N.S. *Mercy*, our hospital ship that also is hosting a number of non-government agencies providing humanitarian aid and support. He was very impressed with those operations and we find it encouraging, especially the precedent of partnering the U.S. military and Federal Government with non-government organizations to provide much needed care. The result has been strengthened good will and trust between our Nation and those we assisted.

MEDICAL ETHICS AND DETAINEE HEALTH CARE

In the shadow of these great accomplishments, and the outstanding reputation of U.S. military medicine, have come allegations and reports that a few members of the military health care team may not have acted properly or met their ethical obligations. These allegations and reports are deeply disturbing to us and to the leaders of military medicine. We want you to know that these reports have been fully investigated (some investigations and findings are still pending) and our policies and guidance and training have been reviewed and, where needed, revised. We have been addressing these matters in a straightforward way, and making whatever improvements are needed. Our message to all levels of the military medical community is that, at all times, our people always must do the right thing and they must always act ethically. For the medical care provided to detainees under U.S. control, we will rely on the professional judgment of our medical staffs and ensure that the standards provided to detainees is comparable to that provided to U.S. members. Importantly, you should know that the lives of hundreds of insurgents and detainees have been saved by superior medical care and treatment provided by U.S. military personnel, often under the same trying conditions we find in treating our own people. We expect our military medical personnel to report suspected detainee mistreatment, including any mistreatment noted during interrogation sessions. Investigations are ongoing and should we discover violations, we will hold people accountable. Currently, the Army and Joint Chiefs of Staff are addressing several recommendations from the various reports and investigations regarding medical issues for detainees in Iraq and Afghanistan. Additionally, over this last year, military

leaders in Iraq have made numerous improvements regarding medical care of detainees. For example, the MTF at Abu Ghraib has been expanded to include a 210-person, 52-bed field hospital. Above all, our policies, simply stated, require that all detainees be treated humanely. U.S. law and policy condemn and prohibit torture, and U.S. personnel are required to follow this policy and applicable law.

HEALTHY CHOICES FOR LIFE

We believe that the long-term, life-style choices people make can affect positively the readiness of our forces. To encourage these positive life-style choices, we have embarked on a new effort, one that reflects our commitment to fostering healthy lifestyles among our servicemembers and other beneficiaries of the Military Health System.

It is clear that we must work harder and smarter to reduce the negative affects of unhealthy behavior choices. Indeed, the negative effects on our military community of destructive choices are a cause for concern. For example, according to DOD cost estimates, tobacco use by the Active-Duty Force generates a \$1.6 billion annual expense in medical care. Combined with the adverse consequences of obesity and binge drinking, the health of our military population suffers significantly. Force readiness depends on the good health of members of our Armed Forces. Long-term success in efforts to promote healthy choices among our members and their families could be among our most valuable and enduring efforts.

While individual health is a personal responsibility—developing and maintaining a healthy and fit force is everyone's responsibility. Our patients tell us that we—the Department—are their most trusted sources of advice in such matters. Knowing that, we believe we can help our military members and their families make a difference in their life-style choices.

In that spirit, over the next 2 years, through a demonstration project called "Healthy Choices for Life," we will focus on building healthier communities through education, intervention and treatment. We have an enthusiastic team of health professionals working with others in the Department to meet this challenge. Our goal is to significantly improve members' health through lifestyle changes, thus enhancing the readiness of the Armed Forces, and eventually reducing the cost to our military health system that adverse choices impose.

TRICARE, THE MILITARY HEALTH PLAN

The TRICARE Program, our health care plan for our 9 million beneficiaries has now fully transitioned to new regional alignment and contracts, which include incentives for positive outcomes based on improved customer service. This transition was a momentous accomplishment and required dedicated work by a highly-motivated professional team. Today's contracts have a stronger customer service focus, apply best commercial practices, and support our MTFs—indeed, our military medical facilities remain at the core of our system.

In spite of our efforts to manage more efficiently, total spending for the MHS, including the Retiree Accrual Fund, will reach \$36 billion in 2005. Spending has essentially doubled in just the past 4 years! Our program growth is very rapid, and it appears likely to exceed \$50 billion within 5 years. Additionally, if current trends continue, over 75 to 80 percent of that spending will be for individuals no longer on Active-Duty or their family members. The expansion of benefits, such as those for our senior retirees, contributes to the growing size of our budget. But, so do other program elements. For example, our total pharmacy program has increased five-fold, that's 500 percent since 2001 and now stands at over \$5 billion annually. Our leaders of military medicine must apply full attention and best management efforts to these matters. We have informed the Service Chiefs and Vice Chiefs, Service secretaries, and other department leaders, including Secretary Rumsfeld, of the facts about our spend patterns, cost trends, funding needs, how we are addressing cost increases, and more. Through these efforts, we have achieved a much better understanding about the financial aspects of our Defense health program and have received solid funding commitments. As a result of these exchanges, we are confident about the state of our program in the near term.

However, looking to the medium to longer term, quite candidly, we are concerned. We face tremendous challenges with a benefit design that does not always reward the efficient use of care. Further, we are increasingly out of step with the benefit design approaches and trends of the private sector. We must address these issues, engage in constructive dialogue, and do what is right for our current and our future generations. My primary goal is to ensure the military has a high quality, yet affordable, health benefit program for the long term.

SHARING INITIATIVES WITH DVA

We continue to explore new avenues of partnership with the VA. Our executive council structure serves as the setting in which the DOD jointly set strategic priorities, monitor the implementation of those priorities and ensure that appropriate accountability is incorporated into all joint initiatives.

The Joint Executive Council recently reviewed and updated the Joint Strategic Plan (JSP) for fiscal year 2005 which includes goals and objectives for the year, as well as performance metrics in the following areas:

- Leadership commitment and accountability
- High quality health care
- Seamless coordination of benefits
- Integrated information sharing
- Efficiency of operations
- Joint contingency/readiness capabilities

We have worked closely with the VA to initiate the demonstrations projects required by the National Defense Authorization Act of Fiscal Year 2003, as well as the Joint Incentive Fund (JIF) projects required by the same legislation. Seven demonstrations are now underway, twelve incentive fund projects are in varying stages of initiation and 56 new JIF proposals have been submitted for review.

We are especially pleased with our work with the VA for the seamless, responsive, and sensitive support to soldiers and marines as they return to duty or transition from Active-Duty to veteran status. An important aspect of this transition is having the individual medical records available when a separated servicemember presents at a VA hospital for the first time. We made significant strides forward by transferring to DOD electronic health information of servicemembers who leave Active Duty to a central repository at the VA Austin Automation Center. Through this repository, VA clinicians and claims adjudicators have access to DOD laboratory results, radiology results, outpatient pharmacy data, allergy information, discharge summaries, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data records and demographic data. To date, we have transferred this electronic health information on more than 2.9 million separated servicemembers to this repository, and the VA has accessed more than 1 million of those records. We believe that this collaborative effort with the VA has been going extremely well and together, the DOD and VA are improving services to our veterans.

RESERVE COMPONENTS HEALTH BENEFITS

At your direction, we are implementing the new TRICARE Reserve benefits that will ensure the individual medical readiness of members of the Guard and Reserve, and contribute to the maintenance of an effective Reserve component force. The Guard and Reserve are doing an outstanding job and they deserve an outstanding benefit. We will provide that for them. We have made permanent their early access to TRICARE upon notification of call-up, and their continued access to TRICARE for 6 months following Active-Duty service for both individuals and their families. We are implementing the TRICARE Reserve Select (TRS) coverage for Reserve component personnel and their families who meet the requirements established in law. TRS is a premium-based health care plan, at very attractive rates, available to eligible members of the National Guard and Reserves who have been activated for a contingency operation, on or after September 11, 2001. This program will serve as an important bridge as the Reserve and Guard members move back to other employment and the utilization of the private health care market.

THE WAY AHEAD

As we begin the second 4 years of this administration, it is an appropriate time to contemplate the way ahead for our Military Health System. The mission is clear—to support our men and women fighting the global war on terrorism, the people who are helping to bring security and freedom to Iraq and Afghanistan, and to care for our Armed Forces wherever they serve around the world. Our top priorities for our health system today are simple. First, to continue to do our utmost to care for servicemembers who go in harm's way. Second, to ensure our health benefit remains intact, affordable and effective. We have challenged the leadership of the Military Health System to be creative and diligent in the pursuit of these missions and priorities. We will advance our programs to care for our deployed heroes—our returning wounded from Iraq and Afghanistan will have special focus. We have made great strides in this direction, but further improvements are possible.

The Department continues to lead and cooperate with other Federal partners in the biodefense of our country and supporting the enhancement of emergency medical preparedness.

We will follow through on our TRICARE governance implementation and together address remaining and emerging issues in our new framework. In key areas we have worked with our private sector partners to identify needed policy changes—and to soon implement these changes.

We will work to complete the medical readiness review, and implement the final recommendations of the Base Realignment and Closure Commission to be released later this year.

We will fully implement our strategic and business planning processes to ensure we effectively address readiness, capital needs, and changing infrastructure. These processes are not simply a window for us in Washington, but a productive way for MTFs, regional directors, and TRICARE managers to manage for the next 10 years or more.

We will pursue higher levels of system efficiency and clinical effectiveness and deploy information technologies and management systems that support greater performance, clarity and accountability. We will implement critical new initiatives such as revised financing, prospective payment, diagnosis-related groups (DRGs), improved billing and coding, and the Composite Health Care System II (CHCS II).

The MHS enjoys a position of national leadership with respect to information technology. Our electronic health record system is the most sophisticated and far reaching of any in the world. We are on track to implement it fully within the next 24 months. Today, on average, nearly 20,000 patient visits daily are being captured by this new system. We have an opportunity, even an obligation, to lead—and so we will.

SUPPORT TO THE SEVERELY WOUNDED

Each of the Services has initiated an effort to ensure that our seriously wounded servicemembers are not forgotten—medically, administratively, or in any other way. To facilitate a coordinated response, the Department has established the Military Severely Injured Joint Support Operations Center (JSOC). We are collaborating, not only with the military services, but also with other departments of the Federal Government, nonprofit organizations, and corporate America, to assist these deserving men and women and their families.

A number of our severely injured servicemembers will be able to return to duty, thanks to their dedication and commitment, and the phenomenal quality of military medicine. Some, however, will transition from the military and return to their hometowns or become new members of another civilian community. These are capable, competent, goal-oriented men and women—the best of our Nation. We will ensure that during their rehabilitation we provide a “case management” approach to advocate for the servicemember and his or her family. From the JSOC here in Arlington, Virginia, near the seat of government, to their communities across America, we will be with them. This will continue through their transition to the VA, and the many other agencies and organizations providing support to them. Our goal is to provide long-term support to ensure that no injured servicemember is allowed to fall through the cracks.

CONCLUSION

The military medical community has often been a powerful influence in building national relationships that foster freedom and liberty. Today, we also directly support our servicemembers who fight to help others secure their freedom. We face real challenges in the months and years ahead in this fight for freedom and liberty. Our Military Health System is truly a precious national asset, and we are most pleased to have the opportunity to help shape and lead it. The men and women of the MHS have worked very hard at research, to protect, to care for and to treat, to manage and to lead. The reason military medicine has succeeded and why it will continue to succeed goes beyond ‘hard work’—it goes to the will and character of the American people. We are confident that our mission—caring for the uniformed servicemembers who keep this Nation safe and secure, and to care for their families—has no greater calling or cause!

The DOD has made tremendous progress in force health protection and surveillance since the Gulf War, and quite a bit since the beginning of Operation Iraqi Freedom. The groundwork has been laid for even greater progress in the near future and we are firmly committed to continued improvement in protection for the health of our servicemembers and in the everyday care and support for all of our bene-

ficiaries. The medical personnel of our combined services have our heartfelt appreciation and full support for their outstanding work.

Thank you.

Senator GRAHAM. Thank you very much, there's a lot to ponder here. I've kind of flamed the debate for myself here a moment, a couple of things you said jumped out at me, Dr. Winkenwerder. You said by 2010, 70 percent of military health care will be consumed by retirees, if nothing changes. You also indicated that there has been zero increase in cost sharing in the TRICARE system, and compared that to other programs in the civilian sector where it's kind of 57 to 87 percent, is that right?

Dr. WINKENWERDER. Yes, sir.

Senator GRAHAM. What ideas do you have about changing that? How can we address that problem in a fair way?

Dr. WINKENWERDER. Well, to be candid, our first step has been to educate everyone, both within the Department, and we spend quite a lot of time doing that with our military leadership to make sure that we all have agreement that we have a problem. That is part of this process, and there are lots of different approaches, at least many. I think it is fair to say, as Senator Coburn said, providing a notion that people are sort of engaged with their health care.

Senator GRAHAM. Does Congress have to approve any increases, is that the way the law is structured now?

Dr. WINKENWERDER. For certain aspects, yes, and for others, we would currently control the authority to do so. But I would just say that it would be our view that any change that we want to make would be best done in cooperation, and in consultation with you, and certainly with others.

Senator GRAHAM. About best practices? I understand your testimony to be that some of your new contracts are going to incorporate a best practice requirement.

Dr. WINKENWERDER. Yes, that's correct.

Senator GRAHAM. Does it have any financial incentive?

Dr. WINKENWERDER. Yes it does.

Senator GRAHAM. Similar to what Dr. Coburn suggested?

Dr. WINKENWERDER. We are currently, with the new contracts, using financial incentives to improve what some people call the administrative processes, timeliness of claims, payment accuracy of claims payment, answering phone calls, being responsive, and even satisfaction of the beneficiaries, and that has certainly gotten people's attention here in the first 6 months of the contract. The next phase, we do not have this in the current contracts, but I think Senator Coburn makes a very good point. He's exploring how to incentivize good clinical performance, that is, the right kinds of practices within health care.

Senator GRAHAM. Do you have any suggestions about a HSA component to TRICARE that would be unique to the military? Do you have any ideas along those lines?

Dr. CHU. Let me, if I could, answer that. I've asked that the DOD look at that issue, just as a matter of simple justice. We offer it now to our civil employees in the Department, and Dr. Winkenwerder is one of them, I might add. It is not straightforward, and much as Dr. Winkenwerder indicated, as far as other health care benefit plans, I think we want to do this in partnership

with Congress if we're going to proceed. We could do some parts of the necessary steps with authority that the Secretary of Defense has, but we cannot necessarily do all of it.

Senator GRAHAM. Let me understand what you just said, Dr. Chu, if you're a DOD civilian you'll have a self savings account opportunity?

Dr. CHU. Congress gave the entire nation—and with that statute also Federal civil employees, and that included of course DOD civil employees. We're looking hard at how to offer such an option on a voluntary basis, again, your choice, to military households.

Senator GRAHAM. I will now recognize Senator Nelson.

Senator BEN NELSON. The legislation, Dr. Chu, you're talking about authorizing civilian employees does not, apparently, extend to the military? Do you think that was an oversight on our part, or is this something we have learned since?

Dr. CHU. I think it reflects the fact that the military benefit is culled out in statute, a separate set of statutes, and governed by those statutes. So if we were going to offer a thoughtful HSA plan, from the research we've done thus far—and we're not finished with that review—we would probably need some additional statutory authority. There are also some significant administrative issues, about how you run a system like ours with two very different plans like this in place at the same time.

Senator BEN NELSON. You would have a "QuadCare" or something like that, you would have to have another plan, I mean, keeping it symmetrical, of course, to deal with that. There would be a different kind of plan because obviously you would have high deductibles in place, et cetera. It might not be a bad idea to try and explore to see if that kind of a system would work for the military as well, perhaps a pilot project or something, would that be appropriate?

Dr. CHU. That is one way to proceed, yes sir.

Senator BEN NELSON. If you had your druthers what would be a way to proceed?

Dr. CHU. I would first like to complete our due diligence as to what are the constraints and issues you would have to confront successfully in order to mount a good program. It may be that if it is voluntary, you could offer it on a broad basis to start with, and that the pilot would really consist of seeing how many people were interested in an option of this sort, but we've not reached that point yet.

Senator BEN NELSON. Mr. Chairman, I neglected to ask to have my full statement placed in the record.

Senator GRAHAM. Absolutely.

[The prepared statement of Senator Ben Nelson follows:]

PREPARED STATEMENT BY SENATOR E. BENJAMIN NELSON

Thank you for holding this hearing, Mr. Chairman. Health care is a vitally important aspect of serving in the military. When we send our young men and women into combat, we know that some will be injured and wounded. When that happens, we owe it to them to ensure that we provide them with the very best health care available. At the same time, servicemembers and their families also have health care needs that must be met. Quality health care is one of the most important quality of life benefits that we provide to our servicemembers and their families.

At the outset, I want to commend the military's health care professionals for the incredible medical care they are providing to troops wounded in Iraq and Afghani-

stan. Many seriously wounded soldiers and marines who would have died on the battlefield in earlier conflicts are alive today because of the world-class medical care they received. They were kept alive by highly-skilled medics who provided immediate care, enough to keep them alive until they could be evacuated to facilities where highly sophisticated, cutting edge, care was available. As I understand it, seriously wounded soldiers and marines are quickly moved from the combat zone to the Landstuhl Regional Medical Center in Germany where they are stabilized, then evacuated to the United States, where they receive the very latest in medical care. Our military health care system is the very best there is, and we intend to keep it that way.

Providing this health care is expensive, and the cost grows each year. Cost of health care is not an issue that is limited to the military—the cost of health care is a major issue that our society is grappling with. I recently met with Dr. Winkenwerder who expressed the Department of Defense's (DOD) concern about future medical cost growth, which could reach \$50 billion in 5 years. We in Congress share that concern. The DOD and Congress need to work together to control military health care costs, but we must do so in ways that do not cut benefits or degrade the quality of care provided to those who are wounded while fighting our wars.

I join the chairman in recognizing one of our own, Senator Coburn, to get his insights on efficient delivery of health care and how it might apply to the Defense Health Program (DHP). I look forward to the testimony of Secretary Chu and Dr. Winkenwerder about how the DHP is functioning and any ideas they have for improvements. I am anxious to hear from the experts on our last panel on their insights into national health care trends and what they portend for the DHP.

Thank you Mr. Chairman. I look forward to the testimony from our witnesses.

Senator BEN NELSON. I do want to compliment you, Dr. Chu, on what's been done with the care of our wounded personnel and soldiers and those who have been wounded in Iraq and certainly in Afghanistan. I've toured Landstuhl and seen what you've been able to do in stabilizing and getting to that base for the appropriate kind of care. Certainly our soldiers and all who are engaged in this conflict certainly have a lot better care. The obvious casualty numbers are lower than they would otherwise be, and I certainly want to commend you and all the military and the civilian personnel who have made this possible, to save lives, and to save as much of the health as they can of those who have been wounded.

Dr. CHU. Thank you, sir—a great credit to the men and women in the field who are doing that hard work as we speak.

Senator GRAHAM. Thank you.

One last line of inquiry, when you talk about expanding TRICARE, or about TRICARE just in general, do you get a lot of input from the community that is being serviced? I have a billing statement here, and this is anecdotal, but it's just used to illustrate a point where the service for the TRICARE patient was \$4,557 for some institutional care, and TRICARE paid \$8,475.81. They paid twice what the bill was requested, and we've been told that the code allowed that much payment for the service, and no one thought to see if it actually came under the code. This, I'm sure, happens in all managed care systems, but our next panel has been very direct in their testimony to the committee about waste and inefficiency. What efforts, if any, do we have ongoing to look at problems like this, to better police TRICARE and to make sure that before we reform the benefits schedules, which I think we have to do, that we look at bringing more efficiencies to the table, and find out where our money is going?

Dr. WINKENWERDER. Well, thank you for that question, that's a great question. I can tell you that nothing bothers me more than to know that either someone has taken advantage of our program, and therefore of the military, and our beneficiaries, and the United

States taxpayers, or that mistakes were made that waste peoples' money. We have a number of audit programs in place to try to prevent that type of incident. I'd be interested in looking into that incident, to make sure we can follow up on it. We want to make sure that we pay what we're supposed to pay and that we don't pay what we're not supposed to pay, and this goes to a variety of situations.

Senator GRAHAM. How do your reimbursement rates compare to, say, Medicare?

Dr. WINKENWERDER. Typically, we're right at our standard, which is the same as Medicare pays now. Our contractor health plans that we work with such as Humana, Tri-West, and Healthnet—those are the big three—are free to negotiate something that might be less than that, but it will depend upon the area of the country. In some areas, they may pay more than that, because of the negotiation, but I do want to refer back to Senator Coburn's concern about the access. We have had some issues in access, and we attended to those. We have a very large network nationally, with over 212,000 physicians, but if you go to certain pockets in certain local areas it is possible, yes, that there could be problems.

But, we've instituted a new process of doing this, at the beneficiary groups' suggestion. There are 20 areas in the country every year that go out and survey the medical providers and the doctors, to ask if they're taking TRICARE, and if they're not, why, and what's going on, and that's been very valuable to encourage our contractor partners to say, "Look, we need to expand, we need to make sure that we have sufficient providers here." The long and the short of it is, at least one measure is asking our beneficiaries themselves about how satisfied they are with access, and it is not decreasing, it's actually improving, slightly, a few percentage points. I think that is a good news story. But it doesn't mean that there aren't problems.

Senator GRAHAM. What are your audits about waste and inefficiency showing? What are they telling us?

Dr. WINKENWERDER. I would have to get back to you with a specific report on that, and I would be glad to do that.

[The information referred to follows:]

TRICARE has multiple controls in place to ensure accurate payment of claims and appropriate expenditure of taxpayer dollars.

One of these controls is the requirement for prepayment review. The contractors use this strategy to prevent payment for questionable billing practices. Providers are placed on prepayment review as part of the administrative actions taken by the contractors. This process allows for a close review of the services rendered and often requires the suspect provider to submit medical documentation to support billed services. In calendar year 2004, prepayment review resulted in a cost savings of \$7.3 million.

Another control is TRICARE's rebundling software, a commercial software package used by all managed care support contractors. The software is designed to detect and correct the billing practice known as unbundling, fragmenting or code gaming. This practice involves separate reporting of the component parts of a procedure instead of reporting a single code which includes the entire comprehensive procedure. An example of an improper billing that is detected with this software is in billing for a hysterectomy. A proper code for a hysterectomy would be represented by a 58150 which would reimburse at about \$2,700. An unbundled billing would contain multiple line items and codes such as lysis of adhesions, exploratory surgery, dilation and curettage, tying of tubes, coming out to over \$7,500. This practice is improper, has been condemned as inflationary by professional medical groups and

is a misrepresentation of the services rendered. Every claim is run through this system of checks and balances. This product does not set coverage or benefit policy—it merely audits the claims prior to payment for appropriate coding. Rebundling software has saved millions of dollars in erroneous payments each year. During calendar year 2004, \$95 million in fraudulent/abusive billings were stopped across all contracts.

TRICARE also mandates that each contractor have a fraudulent claims investigation unit or anti-fraud unit to identify and investigate any pattern of suspicious or any potential fraudulent billings. Artificial intelligence software is also a contract requirement to facilitate data mining to identify questionable billing practices. In calendar year 2004, there were \$6 million in fraud judgments for TRICARE. Another \$2.29 million were identified for administrative recoupment.

TRICARE has established a cost recovery contract as well to determine the extent of potential overpayments to providers for Medicare Cost Report periods during calendar years 1992–1997. The audit identified \$32 million for recoupment involving 2,160 hospital providers. Tricare Management Activity (TMA) is in the process of establishing the next round of cases, consisting of an estimated 550 new cases with a net value of approximately \$7.3 million. This contract is administered by TMA's Contract Operations Division.

An employee at TRICARE has developed a retrospective auditing tool that is required to be used by all managed care support contractors. The software has identified and accounted for almost \$100 million in recoupments or offsets nationally since 1996.

The areas I've covered briefly represent just some of the many additional controls TRICARE has in place to ensure fiscal responsibility—controls in addition to the strong contract performance requirements and financial disincentives for erroneously paid claims.

Dr. WINKENWERDER. I know we regularly recover money into the more than tens of millions—it's probably well over a \$100 million a year—in this type of activity, so it is an important source of cost avoidance that we keep our eye on, and that we set targets to ensure that we're not being taken advantage of.

I will say one other thing about our administrative costs, and that is that—because I'm familiar, having worked with Blue Cross/Blue Shield in the past—that our administrative costs as a percentage of a total health care dollar are lower than just about any health plan that I'm aware of in the past. Some of that is because we don't have to spend dollars on marketing, or advertising, and I think our size also gives us some economy of scale, so we actually have a pretty good administrative cost structure. That is not to say we can't drive it down, we're trying to drive it down through more electronic claims, and electronic commerce and that type of thing, but I did want to just make that one point.

Dr. CHU. If I could add, Senator, on this question of auditing, just for the reasons you're implying—we have a very strong partnership with the Department's Inspector General (IG) on this front. It is a very vigorous program of review. Second, on the question of efficiency, that's the reason Dr. Winkenwerder recommended, and we have adopted, this prospective payment system for our own treatment facilities, that we staff and run ourselves. In the past they would be paid on inputs, depending on the number of people on staff. It's largely backward—looking in terms of budgeting, based on what you have last year, and then what you anticipate for next year. In the future—this is a 4-year transition—but in the future they'll be paid based on the anticipated work load by diagnosis, and they'll be paid, essentially, those same Medicare rates that anybody else would pay, and what that is, is already identified for us inside the Department. Some of our hospitals look very good, and they would make a “profit” if they were in the private sector.

Some of our hospitals probably have some significant work to do to bring themselves up to the standard, and that's the purpose of this 4 year transition.

Senator GRAHAM. That's terrific, Senator Nelson, anything more?

Senator BEN NELSON. Dr. Chu, under laws that we've passed the last couple of years, the Reserves, and the families, have become eligible for this military TRICARE benefit, up to 90 days prior to mobilization in order to make sure—among other things—that the military personnel are ready to go. Now, the Reserve Officer's Association reports complaints that units are being ordered to Active-Duty using group orders, and when they attempt to enroll in TRICARE, they're told that they need an individual order to enroll. But, they don't get individual orders until they arrive at the mobilization station. We seem to have an impossible situation, where you can't quite get there with what was intended. So, even though they are eligible, they just can't get individual orders until they actually report for Active-Duty, is there anything we can do? Or were you aware that we are running into this sort of a snag?

Dr. CHU. I had not heard of that until your staff mentioned it earlier this afternoon. We'd be delighted to look into that and make sure we get the situation put on the right footing.

[The information referred to follows:]

The Service/Reserve component personnel activities are currently recording eligibility for TRICARE coverage for Reserve component members and their family members in the Defense Enrollment Eligibility Reporting System (DEERS) when the Reserve component issues delayed effective-date Active-Duty orders, up to 90 days before the member is scheduled to report to Active-Duty. The DEERS transaction by the personnel activities is all that is required for the member and their family members to be covered by TRICARE; action by the member is neither required nor possible to get TRICARE.

Nonetheless, eligibility for TRICARE coverage as recorded in the DEERS by personnel departments is frequently confused with enrollment into TRICARE Prime as a result of an enrollment application submitted by a beneficiary to the TRICARE regional contractor. (TRICARE Prime is an option similar to civilian HMOs that names a primary care provider for each eligible beneficiary who will serve as his or her Primary Care Manager.) Eligibility in DEERS, not orders, is the prerequisite to TRICARE Prime enrollment. DOD policy was revised last year to ensure that mobilizing Reserve component members do not apply for enrollment into TRICARE Prime until reaching their final duty station where a Primary Care Manager can be named for them. However, their eligible family members are welcome to apply for enrollment into a TRICARE Prime program as soon as they become eligible in the DEERS depending upon local availability.

In my memoranda of January 7, 2004, and February 11, 2005, to the Assistant Secretaries of Military Departments for Manpower and Reserve Affairs, I provided guidance on recording eligibility in DEERS for National Guard and Reserve members, and their eligible dependents. The guidance directed the Services to provide electronic files to DEERS of eligible members who have been issued either an individual mobilization order or are on a unit alert order with approved annex identifying individuals to whom individual mobilization orders will be issued. While guidance has already been published that should preclude the reported problem, I will reissue guidance to reinforce the need to record eligibility in DEERS, with the appropriate effective date, as soon as an approved order has been issued.

Senator BEN NELSON. Obviously sometimes putting in place something that directs something like this to get done runs into a hurdle, or runs into a snag, and this is clearly one of those situations, because it's not intended to do what was an unintended result, which I hope we can resolve.

Dr. CHU. Yes, sir, and if your office can provide details of which units thought they were so disadvantaged, that would help us track it down more quickly.

Senator BEN NELSON. We'd be happy to do that. Now Dr. Winkenwerder, I have a little bit of questioning about mental health counseling. It's always going to be an issue we deal with when it comes to health care. One question as it relates to servicemember health care, and another as it relates to families, dependents.

Apparently, a recent Army study found that incidents of major depression, generalized anxiety, and post-traumatic stress disorder (PTSD) were significantly higher after combat duty in Iraq or Afghanistan. Obviously, we know that many who need that kind of care don't necessarily seek it because of the stigma that's attached to it. In March of this year, you issued a memorandum to the Assistant Secretaries for all of the Services, directing them to extend the Pentagon's current post-deployment health assessment process to include a reassessment of global health, and then with a specific emphasis on mental health, to occur 3 to 6 months post-deployment. Do you know what has happened as a result of your directive?

Dr. WINKENWERDER. Yes, Senator, thank you for asking that question. This is an area that has been a real concern for me and a real priority.

We're placing people in difficult situations, in stress, in combat and it goes on. Group after group, and it's a tough situation, so I think we're doing a number of things. We have Combat Stress Control Teams in theatre, who focus on identifying mental health concerns right up front, immediately after deployment. This latest step that we've taken that really came as a suggestion from our front line people—it wasn't an idea that came out of my office said, "Look, we really think we need to have everybody go through this sort of screening procedure, with a questionnaire and a face-to-face interaction at about 3 months, because that's when it seems like we're seeing some family adjustment problems, or some social problems, or anger or alcohol, and we can really help people if we do this," and I asked them, I said, "Do you think we should make it mandatory?" The answer was "yes."

So, in the Services, many times—I think you know having served on the Armed Services Committee when we tried to put a big new program like this into place—there's some resistance and so forth, people really welcome this idea, and so I just was briefed on it this week. We're on schedule, we believe, to implement this starting in June. It will roll out over the summer months, and it will be a permanent thing from now on, so we'll look forward to finding out what we've learned from this. We will also be reaching out to the guardsmen and reservists, even people who have separated, we're going to contact them by phone or by e-mail or by whatever means possible to make sure we make contact.

Senator BEN NELSON. I think that's an excellent approach, and I hope that you will keep us advised as to how it turns out. I have one further question on this as it relates to the family members. Apparently there's some challenge with certain families, and civilian health care providers don't accept TRICARE, and so you end

up with some people who are stranded without the TRICARE available to help them on some of the mental health counseling they need. Are you aware of that, and is there anything that has been done to date?

Dr. WINKENWERDER. I would have to take that specific concern and get back to you on it.

[The information referred to follows:]

One of the most important things that TRICARE can do is to help beneficiaries locate a provider who will treat them. The TRICARE Regional Offices, along with the regional Managed Care Support Contractors, can find a TRICARE authorized provider for beneficiaries.

Admittedly, we have access to care challenges particularly in rural areas. Through TRICARE Standard, the fee-for-service coverage option in TRICARE, we serve about 2.5 million beneficiaries under age 65, many of whom live in rural areas. TRICARE Standard is an important component of the TRICARE triple option benefit that provides more freedom of choice of provider at a somewhat higher cost than TRICARE Prime or TRICARE Extra. TRICARE Standard has worked well for Active-Duty families, retirees, and their families for over 35 years, and the Department is committed to enhancing and improving it. Unlike TRICARE Prime, with its uniform access requirements for enrollees, TRICARE Standard access varies from place to place, depending on proximity of military health care and the extent of the local civilian health care system.

Moreover, we are pleased with recent survey results which show that providers are accepting TRICARE patients. In accordance with Section 723 of the National Defense Authorization Act for Fiscal Year 2004, DOD conducted a survey of physicians in 20 market areas around the U.S. regarding their acceptance of new TRICARE patients. Beneficiary groups identified these areas as having the greatest anecdotal evidence of access problems. These areas included over 11,000 physicians located in Anchorage, AK; Boise, ID; Colorado Springs, CO; Fredericksburg, VA; Las Vegas, NV; Rochester, NY; Atlanta, GA; Bainbridge Island, WA; Buffalo, NY; Cheyenne, WY; Fayetteville, TN; Greensboro, NC; Jackson, MS; Laurel, MS; Meridian, MS; Philadelphia, PA; Portland, OR; Princeton, NJ; Utica, NY; and Williamsburg, VA. Survey data showed that most doctors were accepting new TRICARE patients. Since these areas represented the locations where there were beneficiaries' greatest concerns about access to care, the results suggested that we do not have major problems with access.

We will continue, however, to work hard to find ways to improve access to care for TRICARE Standard users. The surveys required by Section 723 of National Defense Authorization Act for Fiscal Year 2004 will continue over the next few years, and we should get additional important information to help focus our efforts.

In addition, to address immediate needs for counseling, servicemembers may access the Department's Military OneSource, a program designed to help servicemembers and their families deal with issues such as personal and family readiness, emotional well-being, addiction and recovery, and parenting and child care. Through Military OneSource, master's level consultants are available 24 hours a day, 7 days a week, 365 days a year. Anyone may call to speak with a consultant, or they may go online to access information or to e-mail a consultant. Consultants are available to discuss confidential issues relating to emotional and mental health.

Finally, in locations where there may be inadequate access to network providers, members and their dependents may seek care from any authorized TRICARE mental health care provider. If members are enrolled in TRICARE Prime or TRICARE Prime Remote Active Duty Family Member (TPRADFM), and they are referred to a non-network provider, TRICARE may pay up to the legal liability amount (Champus Maximum Allowable Charge (CMAC) plus 15 percent). If not enrolled in Prime or TPRADFM, members and their dependents may use TRICARE Standard. For reservists and their dependents under the Reserve Demonstration, TRICARE will waive their Standard deductible and pay 115 percent of CMAC to nonparticipating providers.

Dr. WINKENWERDER. I have not been informed that, that at least, is a broad issue, but we would be glad to look into it.

Senator BEN NELSON. We'll try to get you some more information on that. Finally, I think in fiscal year 2001, the National Defense Authorization Act required the DOD to conduct a demonstration project, authorizing licensed mental health counselors to practice

independently, and I think back in March 27, 2003, you provided a letter in which you stated that the Department will submit its final report to Congress in March 2005. We might have missed the March date. Do you have some idea?

Dr. WINKENWERDER. Yes, sir, I know that report is coming to my office right now. I literally just began to read it. It is a big report. I wanted to make sure I really understood it well before we reported back to you, but it should be to you within a couple of weeks.

Senator BEN NELSON. Can we count on that for summer reading, maybe? [Laughter.]

Dr. WINKENWERDER. Yes, plenty of time for summer reading.

Senator BEN NELSON. Thank you.

Senator GRAHAM. One last question, what is the administrative cost of TRICARE?

Dr. WINKENWERDER. I can't give you a precise number, but it is in the single digits. But some of it depends upon how you define administrative costs. Let me just say, for example, the cost to have Surgeons General of the Army, Navy, and Air Force and the TRICARE office—not all of that is administration, some of that is what you would call “Leadership” or “Direct Support” to the troops—and if you're talking about the purchased care aspects, the TRICARE networks and so forth, again it is well below a 10-percent number. The typical number, again, in the private sector that I'm familiar with is around 12, 13, 14 percent, so we think we're several percentage points below that.

But I'm a believer that, again, as I said, as more and more electronic commerce and more and more efficient ways of doing things are derived, we ought to be able to drive that number down continually. So, we look to do that.

Senator GRAHAM. Thank you. Anything Dr. Chu?

Dr. CHU. No, sir. Thank you very much.

Senator GRAHAM. Thank you, you've been very helpful. Our next panel? Thank you both.

We want to thank you all very much for coming today and your patience, it's been a very good hearing thus far,

I appreciate your participation. Dr. Blumenthal, Dr. Galvin and Ms. Hosek? Thank you all for coming, and if you don't mind, for the record, just introduce yourself and your organization, and we'll start with Dr. Blumenthal and take testimony.

Dr. BLUMENTHAL. My name is David Blumenthal, I'm a practicing general internist and also Professor of Medicine and Health Care Policy at Harvard Medical School, and also direct an Institute for Health Policy at Massachusetts General Hospital in Boston.

Dr. GALVIN. I'm Dr. Robert Galvin, Director of Global Health Care for General Electric.

Ms. HOSEK. Susan Hosek, I'm a Senior Economist at RAND, and I am co-Director of RAND's Center for Military Health Policy Research.

Senator GRAHAM. Again, we're very lucky to have you all, we appreciate it, Dr. Blumenthal?

STATEMENT OF DR. DAVID BLUMENTHAL, M.D., DIRECTOR, INSTITUTE FOR HEALTH POLICY, MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASSACHUSETTS

Dr. BLUMENTHAL. Mr. Chairman, Senator Nelson.

It's a privilege to be here and to share my views on the military health system and the cost problems you're facing. I will summarize my remarks and request that the full text be submitted for the record.

I'm not an expert on the military health system, I study other aspects of the health care system, but it is my understanding in listening to the testimony today, it's confirmed that the military is now venturing into joining the problems that the rest of our health care system is dealing with, and I would like to focus on those with the hope that it provides some lessons for your efforts to deal with the military's particular issues.

The area I would like particularly to concentrate on is the one that I think is most relevant to TRICARE for Life, your programs for older retirees, those over 65, because they—in many ways—constitute for the rest of the American health care system, the biggest challenge that we face, that is, older Americans, and the burden of illness that they live with. The challenge is how to get value for our money for expenditures for an aging population that is living longer with chronic illness and has ever greater and more complicated opportunities for treatment, with more bio-medical information and technology to treat them. That is both our blessing, and from a financial standpoint, our curse.

I don't think there are any magic or silver bullets here. I think you're in for a long struggle as the rest of us are, and the rest of our health care system. There are no simple solutions. This is a campaign that has to be waged over a long period of time with many efforts at trial and error and experimentation.

Let me talk a little bit about the sources of cost increases as I perceive them, for elder Americans. As you are well aware, the Medicare Program experiences very marked cost increases year to year. These in the earlier years of this decade have ranged from 6 to 11 percent annually, and that's about how they've run through most of the history of the Medicare program. As you well know, Medicare beneficiaries have considerable burden of co-payments, so co-payments are not an instant solution to the containing health care costs.

When you think about the cost of this population I think you should think about three things. First of all, you should think about chronic illness, a second thing you should think about is technology, and the third thing you should think about is opportunities for improvement in the area of chronic illness. It is chronic illness that is overwhelmingly the cause of higher costs for our older population.

If you look at the Medicare program, Medicare beneficiaries with five chronic conditions cost 15 times as much per year as those with no chronic conditions—15 times. Those with five chronic conditions account for two-thirds of all Medicare expenditures. If you have five chronic conditions, that portion of our Medicare population that has five chronic conditions—

Senator GRAHAM. Is that per person?

Dr. BLUMENTHAL. Two-thirds altogether, and 96 percent of Medicare spending goes to individuals with one or more chronic condition. The second point I wanted to make is about technology. If you look at why expenditures are increasing year to year on these patients with chronic conditions, the reason is we're doing more and different things for them. One example of these more and different things, which is well known to the public, is coronary angioplasty and stenting for narrowed coronary arteries, the kind of procedure that Vice President Cheney has gone through. We didn't have that 20 years ago. It saves lives, and it's expensive, and we pay for it, and ought to pay for it.

Another example is a new way of screening for a condition called abdominal aneurysm, which is the swelling of a major artery in the stomach, and if it bursts, it is almost certainly fatal. We now screen for that and can operate on it, and prevent its bursting and save lives. We didn't know how to do that, just a few years ago. So these things are available to us. It's very hard to say "no" to them, and the march of technology is very hard to turn back once it gets going.

A third point that I want to mention has to do with opportunities for improvement, and I think my colleagues will say more about that. The first thing is that Medicare has obvious inefficiencies, and perhaps the most clear example of that, or illustration of that is the fact that our country pays twice as much for the care of an older person in Baton Rouge or Miami each year than it does in Oregon or Minneapolis. So twice as much in one place than another with no evident explanation to the illness of the beneficiary, and no evident impact on the outcome of the beneficiary. That differential implies there's opportunity for cost saving.

The other point I want to make is that we can treat our elderly patients better than we do. There's obvious evidence that they don't often get the care they need.

There are opportunities for quality improvement, and Senator Coburn referred to those, and I think my colleagues will also refer to them—what are some ways in which we might think about dealing with these, both the opportunities and the problems?

I want to say that all of these are partial solutions and they are hopeful aspects of the health care system, but much remains to be learned about them. One is through health information technology, this has been a very important aspect of the President's program. I think it offers opportunities to conserve funds and improve quality if implemented, and the military already, I think, has made a major effort to do that within their military health system.

A second is a program or set of programs called Disease Management, which aim to bring—for the chronically ill—a whole bunch of services together and mobilize them, organize them and apply them in a timely and effective way. There's a lot of experimentation with that going on in the Medicare program right now, and the military system should track and learn from those experiments.

You heard something about pay for performance, I think Dr. Galvin, in particular, will say more about that. You've heard something about reporting publicly about the quality of care and performance, and Dr. Galvin will say more about that as well. I consider that a promising strategy.

Finally, I think the military has something to learn about the Veterans' Health Administration (VHA). The VHA has undergone a remarkable transformation in the last 10 years in terms of both the quality and efficiency of care that it provides. It suggests that in some respects and in some settings, organized systems of care have major advantages in caring for the chronically ill elderly. I think this is a very important undertaking that you're engaged in, trying to bring efficiency into your military health system while preserving the benefits, and maximizing the health of the armed services and their retirees. I am grateful as an American that you're involved in this, and look forward to answering any questions you may have.

[The prepared statement of Dr. Blumenthal follows:]

PREPARED STATEMENT BY DR. DAVID BLUMENTHAL

Mr. Chairman, members of the Subcommittee on Personnel, it is a pleasure and a privilege to appear before you today to discuss the current status of the Military Health System (MHS) of the United States Armed Forces. My name is David Blumenthal. I am a practicing general internist in Boston, Massachusetts, as well as Professor of Medicine and Health Care Policy at Harvard Medical School and Director of the Institute for Health Policy at Massachusetts General Hospital and the Partners Health System, also in Boston. I also direct the Harvard University Inter-faculty Program for Health System Improvement.

Like all Americans, I recognize the critical importance of the MHS to maintaining a strong national defense. Nothing is more vital to the readiness of our Armed Forces than caring promptly and well for the illnesses and injuries sustained by the men and women who volunteer to serve. Furthermore, given the uncertainties associated with obtaining health insurance in our civilian sector, the assurance of retiree health coverage provides an increasingly important tool for recruiting qualified individuals to our volunteer military. Therefore, the interest of this subcommittee in the health of our MHS should be welcomed by all Americans.

Before proceeding, I want to make clear to the subcommittee that I am not an expert on the MHS, and for that reason, I do not intend to comment directly on its accomplishments and challenges. Rather, what I propose to do is highlight some ongoing trends in the U.S. health system generally that may be relevant to thinking about the MHS. From my limited understanding, developments in the civilian health system of the U.S. are becoming more important to the MHS since an increasing number of beneficiaries of the MHS are receiving care outside military facilities. This is particularly true, I believe, for one very important group: military retirees over 65 who are eligible for the Medicare program, and are now able to enroll in TRICARE for Life (TFL). The involvement of the MHS in caring for Medicare-eligible Americans means that the Department of Defense (DOD) is getting to know up-close and personally some of the most difficult problems facing the Medicare program and the American health care system generally: how to get value for expenditures on the care of an aging population that is living longer with chronic illness in an age of exploding medical knowledge and technology. This is a challenge facing not only the MHS and the U.S. health care system, but every industrialized country around the world, and it is the challenge on which I would like to focus my remarks today.

To eliminate any possible suspense, let me go right to the bottom line. There are no silver bullets, no shining examples of success, for dealing with the increasing costs associated with the care of Americans generally and older Americans in particular. The MHS has entered territory where, to use military analogies, the fight will be waged foxhole by foxhole over the long term. Don't expect any brilliant maneuvers, any Inchon-style landings, to sweep away the problem of increasing health care costs for the elderly. Rather, to get the best value for the dollar in its new commitment to older military retirees, the DOD will be forced to experiment, innovate, try and often fail—unless it chooses to give up territory by reducing its involvement in the care of this demanding population group.

COSTS OF CARE FOR OLDER AMERICANS.

Though I will not dwell on the benefits of care for older Americans in the U.S. today, I would like to balance my subsequent remarks by noting the enormous progress that our health care system and its health care professionals have made

in improving the health and health care of Americans generally and older Americans in particular. Indeed, the availability of those benefits—seen in increased life expectancy for the over 65, reduced rates of disability for that population, increased survival from particular illnesses like cardiovascular disease and stroke—is what makes the cost challenge so difficult. If the benefits were not so clear and palpable, it would be easier simply to reduce our investments in health care for this population. Furthermore, if those benefits did not exist, it would be less distressing to note another problem that plagues our civilian health care system: its failure, despite all that we spend, to provide beneficial services to many older Americans who need them.

The costs of care within the Medicare program have increased steadily since the program's inception in 1965. In the first 3 years of this decade, growth rates in spending ranged from 6 to almost 11 percent annually. Several salient observations about the costs of care for older Americans within our civilian health care sector should be kept in mind as the executive branch and Congress consider approaches to containing costs within TFL.

First, the costs of care in the United States generally, and for older Americans in particular, reflect overwhelmingly the costs of caring for chronic illnesses, such as high blood pressure, heart disease and cancer. I would expect that TFL's costs will reflect this same phenomenon. The care of individuals with chronic conditions accounts for 78 percent of health expenditures in the United States. Individuals with more than one chronic condition account for a hugely disproportionate share of national health care spending. Patients with more than 5 chronic conditions have annual average health care bills that are 15 times that of individuals with no chronic conditions. Those with more than one chronic condition account for 96 percent of Medicare spending; those with more than five account for two thirds. Thus, there is no way to find a solution to the cost problems of TFL without improving the way we care for the chronically ill elderly military retiree.

Second, when we drill down to find out why costs are increasing for Americans—and especially those with chronic illnesses—we find that about 50 percent of the annual increase in costs can be attributable to doing more and different things for patients. The remaining 50 percent result from inflation generally, from incremental inflation in the medical sector (so called medical inflation), and from the aging of the population. What does doing more and different things mean? Let me give you some concrete examples from the care of patients with cardiovascular disease.

One example is the use of angioplasty and the placement of stents in the coronary arteries of patients who have narrowing of those arteries. We now routinely perform this procedure for patients in the midst of heart attacks. Twenty years ago, there were no stents. Only recently has it become clear that using them in the midst of a heart attack saves lives. The procedure is extremely expensive, but it produces clear benefits.

Another example is screening for so-called abdominal aortic aneurysms, which are weaknesses in the walls of one of the main arteries that carries blood pumped from the heart to other organs of the body. Such aneurysms can burst suddenly, and the result is massive internal hemorrhage and almost certain death. It is now clear that by screening older patients for these aneurysms and operating on them when we find them, we can prevent their rupture and save lives. We didn't know this 10 years ago. The cost is very large.

A third example of doing more and different things is screening older Americans for cancer of the colon using colonoscopies. Twenty years ago, colonoscopies were done only when patients displayed symptoms of possible illness. Now they are done every 10 years for everyone over 50, and more frequently if people have a family or personal history of colon cancer or polyps.

I could give you many other examples of changes in health care practice that have contributed to the growing costs of caring for older Americans, especially those with chronic illness. The point is that care costs more in part because, as economists would say, the product we are buying has changed: it is a more complex and in certain ways higher quality product than it was 10 or 20 years ago.

A third general point to keep in mind about trends in health care for older Americans is that it needs improvement, and that this is likely to be the case for the care purchased on behalf of TFL beneficiaries as well. There are at least two ways in the health of older Americans falls short.

The first way is that it is wasteful. Despite all the positive things I have noted about health care of our elderly, it is quite clear that it could be delivered at lower cost. This is most apparent in the huge variations in health care expenses per capita in different geographic regions of the United States. Medicare spends more than twice as much each year to take care of older Americans in Miami or Baton Rouge than it does in Eugene, Oregon or Minneapolis. There is absolutely no evidence that

these differences in spending make the elderly in Baton Rouge healthier than in Minneapolis—indeed, there is some evidence to the contrary. The best predictor of Medicare spending per capita seems to be not the intrinsic health needs of patients but the number of doctors and hospitals in the community.

The second way in which the health care of older Americans could be improved is by making sure that they get the best care we know how to provide. Many studies demonstrate that the quality of health care provided older Americans is deficient. Heart attack victims often don't get the drugs they should; diabetics don't get their blood sugar tested or their eyes examined regularly; patients with asthma, depression or heart failure don't get indicated medications.

This, then, is the new terrain in which the MHS must wage its campaign to care for TFL beneficiaries: a health care system that is dominated by the needs of the chronically ill, that is doing more and better things for them than ever, but at the same time, is in many ways wasteful and plagued by quality deficiencies. The question that TFL must address, like many other stakeholders, is how to care for this demanding population in a way that preserves the best aspects of our private health care system while improving on its problems.

IMPROVING HEALTH CARE FOR OLDER AMERICANS

As I have already indicated, we do not have a stockpile of proven weapons for accomplishing this demanding set of objectives. What we have is some interesting ideas and some ongoing experiments. Some of these ideas are powerful; some of the experiments are promising. The MHS also seems well positioned to take advantage of some of these ideas and experiments.

The first idea—already well on its way to widespread testing—is greater reliance on information technology to improve quality and reduce costs of care for all patients, including the older chronically ill. Health information technology (HIT) is a health care priority for the current administration because of its promise to improve the coordination and integration of health care, and thereby, to prevent waste and improve quality of services. The evidence supporting the benefits of HIT is far from complete or conclusive, but the technology has a compelling logic that makes the current emphasis justified. The MHS already has a robust HIT system for the facilities it operates, and this gives it an advantage in providing care within those facilities to TFL patients. This is one of several reasons that directing TFL beneficiaries to MHS owned and operated health care settings makes a good deal of sense.

A second idea is to mobilize resources effectively in the care of chronically ill patients through several promising strategies. One is the use of so-called disease management techniques. These involve a variety of tools: reminders to patients, reminders to doctors, the creation of community-based support systems for involving families in the care of chronically ill patient, greater reliance on home care, and the use of information technology. The goal is to weave them into a coordinated plan of attack for making certain the chronically ill patients get the right care at the right time, nothing more, and nothing less. The Medicare program has embarked on an unprecedented national experiment to test the value of disease management programs. TFL should watch that experiment closely and be prepared to learn from its lessons. Indeed, the TFL may want to launch its own experiments tailored to its own special circumstances.

Still a third idea is the pay for performance strategy, which my colleague on this panel, Dr. Robert Galvin, will discuss in detail. This is another approach that is both untested and compelling in its intuitive appeal. Medicare is also experimenting extensively with this approach, and it would be worthwhile for the MHS to develop similar efforts that are adapted to its own circumstances. In this regard, another experiment that TFL should watch closely is under way in the United Kingdom. In its new contract with the Nation's general practitioners, the British National Health Service has promised to increase payments to GPs by up to 30 percent if they meet specified quality goals. The effects of this program on the costs as well as the quality of care will be extremely interesting to watch.

A fourth idea, related to the third, is public reporting of quality and cost performance by health care providers. The limited evidence concerning quality reporting suggests that it stimulates some health care organizations and providers to examine their own quality and efficiency, and that the result may be improved performance in certain respects.

A fifth idea is to try, as the MHS is already, to care for as many patients as possible within its own health care facilities. There are a number of reasons for doing this. One reason is the example of the Veterans Health Administration (VHA) which is increasingly demonstrating that a large, centralized, public health care system can deliver services to chronically ill patients in ways that are higher in quality and

at least as efficient as the fee for service system. The MHS may be able to replicate the success of the VHA in caring for older patients. Another example of the potential advantages of organized systems of care in managing the problems of older, chronically ill Americans is the Kaiser Permanente System, which has pioneered in a number of reforms to improve the efficiency and quality of care, including HIT and disease management.

These initiatives, approaches and programs offer some hope that TFL and other stakeholders in the U.S. health care system can manage the central health care problem of our time: providing the older chronically ill the benefits of modern health care services in an affordable way. Achieving victory in this struggle will require as much ingenuity and perseverance, and perhaps more, than any other mission facing the Armed Forces of the United States. But it is well worth the effort.

Thank you for your attention. I would be pleased to answer any questions you may have.

Senator GRAHAM. Dr. Galvin?

**STATEMENT OF DR. ROBERT S. GALVIN, M.D., DIRECTOR,
GLOBAL HEALTH CARE, GENERAL ELECTRIC COMPANY**

Dr. GALVIN. Mr. Chairman, thank you. Senator Graham, Senator Nelson, I appreciate the opportunity to tell you how leading employers in the private sector are managing their health care costs. I mentioned my formal title before and what I do at GE is somewhat similar to Dr. Winkenwerder's role with DOD, but on a smaller scale. It's oversight of the design, operations, and financial performance of the health benefits we offer our employees plus looking after their overall health.

I was impressed, trying to think through how I could contribute today—and excuse my voice by the way, my cold hasn't healed—at how similar some of the challenges are between DOD and GE because we have highly-trained, well-educated work forces, and the healthier they are, the more productive they are. I think the military is the same way. Second, despite our size and our profitability, and the size of your budget, these health care costs hurt, they squeeze, and it's a very significant pressure that we have to deal with all the time. Third, and probably most significant, is the daunting challenge of trying to reign in these excess costs while keeping people happy, while doing the right thing in terms of benefits and not alienating our work forces. These are significant challenges.

Let me say at the outset, that unfortunately I don't have the answer. We certainly have not found the answer to this set of challenges but I'm going to share with you today a couple of ideas we have tried to implement and which I think have been positive.

I would say right off the bat that one thing we have learned is how critically important communication is. Whenever we have to make benefit choices, whenever we have to make decisions that aren't uniformly popular, what we have found is that the more we can do face-to-face communication, the better it goes. I think that one of the most important lessons that former CEO Jack Welch taught was that when you repeated your message to the point where you were tired of hearing yourself talk, that meant you were about half-way towards getting your message across. Because health care is always personal, the more we can communicate about charges that address cost increases, the better off we are.

Health care costs are rising rapidly today for many reasons. As benefit managers on the employer side are trying to manage these

costs, we tend to separate the causes of cost increases between those we can't do much about—technology, aging—and those where we think good management can make a difference.

I'm going to focus on two of those today—benefit design, which I'll go over quickly, and then how we can use procurement to address waste in the health care system that you've heard described in previous testimony.

There are several other areas that drive costs, and by not discussing them I don't mean to give them short shrift. Population health, as Senator Coburn was talking about, Senator Graham, you spoke about on the financial control issue, which is a very big issue in a complicated trillion dollar plus system, but given that I have limited time, I'm going to go ahead and focus on the two aforementioned areas.

On the benefit design issue the private sector has a saying, that "benefit design is destiny." We spent a lot of time thinking about benefit design, because it is like the blueprints of a house, and essentially, what you do with your benefit design, the cost sharing, and the richness of your design, is going to very much dictate your experience. Now, you can still control it after you've done this, but we spent a lot of time thinking about it, and we really look at three areas.

The first area is satisfaction, because by definition health benefits are supposed to be "a benefit." It is supposed to lead to satisfied employees, so we do annual satisfaction surveys, we take them very seriously. I, as the leader at GE, spend about an entire day every 6 months reading through the individual comments that people make, and it turns out that a lot of people that take the time to write are unhappy, but I think you learn a lot about how to have more people more satisfied.

A second issue which is very important is the relative value of the design versus what else people can get, the richness or value. We always term that as "No good deed goes unpunished," and what I mean by that is, in the impulse to be very generous and to give great benefits, and to not have people pay much, we end up creating two difficulties.

The first involves an insurance term known as adverse selection, which means basically that people who have a greater need for medical care will seek the richer, most generous plan. Lots of employers, like GE, eventually have gone to the extent of saying to our employees, "If you could get coverage through us now, for example, and choose not to, then you're going to pay us a fee for the year." But, it's, I think, pretty significantly happening, although I'm no expert in the military health system, in this new retiree plan that you have.

The second feature is cost-sharing. We know very clearly that the use of health services is "elastic" and evidence is actually very good, it came out of RAND a long time ago, that the less people pay for services, the more they use. Now, conversely, the more they pay, the less they use. You do have to be very careful in health care because if you charge too much, some of the stuff they don't do is the stuff they need for chronic diseases. But we pay a lot of attention to this.

The overall feeling in the private sector is that the sharing between the employer and the employee should be somewhere around 70 percent employer, 30 percent employee. We do a lot of benchmarking to make sure that happens. We do updates of cost sharing at GE, we collectively bargain every 3 years, but many companies without collective bargaining obligations do it every year. It's not a way of penalizing the beneficiary but simply saying, to keep this viable, we need to maintain this ratio.

I'm going to move from benefit design because we've talked about it before and I'd like to address procurement, and how we can address waste in the health care system. I think Senator Coburn and Dr. Blumenthal mentioned it, but over the last 5 years, the Institute of Medicine and others have come up with some startling findings, particularly startling to those of use who grew up in this health care system, and consider it the best anywhere, which is about half the time, people aren't getting treatments they need to get. About 30 percent of the tests that are ordered and procedures that people are getting are probably not necessary, and probably don't yield value. That, very interestingly, as Dr. Blumenthal mentioned, not only are there differences between States for the same outcome, how many services are used, we see it in the same towns. In every major market that we're in we can look and see that some hospitals—

Senator GRAHAM. Do best practices address this?

Dr. GALVIN. Yes, they do, and I'm going to get into pay for performance, which I think is all about best practices. The impacts of getting to best practices are real. If you take the couple of billion dollars we're spending at GE, or the \$36 billion you spent and take the 30 percent waste—they could even cut that in half—there's a lot of money out there. So, I think the question to us is what do we do about getting at that waste. The Institute of Medicine (IOM) had a lot of reasons, and Dr. Blumenthal mentioned one of them, which is information technology, and they're all very important. One of the ideas that I think is particularly relevant to organizations like GE and the military and Congress is that they felt that there was a failure of procurement, that the people purchasing these health care benefits were not holding the system accountable, and were not being clear about what it was we wanted from the system. This is not necessarily just the health plan, this is in claims statement. This isn't whether there are enough doctors, this is actually about what's happening in terms of what procedures are being done, and how much things cost.

So, we took that on a number of employers, started something called the Leapfrog Group, which is a non-profit corporation. There are about 150 employer members, as is Medicare, and we decided we were going to try to figure out how to apply procurement processes to make things better. What we decided was to include in our contracts with health plans, as the three that TRICARE has, two features that we were going to make a condition of doing business with us, and then we were going to measure contract administration to make sure it would be done.

The first feature is transparency. Transparency simply means that we ought to have publicly available information about the performance of doctors and hospitals. It's remarkably the case that we

have very little today. I should say that there isn't a lot of scientific proof that if that kind of information is available, that waste will necessarily go away and quality will get better, but on the business side, we believe if you can't measure something, you can't manage it, and we think there's enough validity in this idea to move forward on this. Some interesting data from our own population is that only 35 percent of GE employees are going to hospitals, when we measured them, that are the best and most efficient. That means 65 percent of our employees aren't going to these facilities. When we asked our employees, "If we gave you information what would you do?" Eighty percent of them said they would use that information to change providers, but in many of these handwritten notes that accompanied the survey, they said, "But I don't have any information." So that was part of the importance of transparency.

The second feature that we put in contracts pay for performance. As Senator Coburn mentioned, there's no connection between performance and payment on our current payment system. The best hospital doing bypass surgeries get paid by Medicare exactly the same as the worst hospital doing bypass surgeries. I think it is a cardinal rule in procurement that you get what you pay for.

We started a program with a number of large employers called Bridges for Excellence, where physicians that do better get rewarded for treating chronic conditions, as Dr. Blumenthal mentioned. I have a couple of more points, and then I will end. There's a lot of interest in this, Mark McClellan, the administrator of Medicare favors these ideas as do Medicare Payment Advisory Commission (MedPAC) and the House Ways and Means Subcommittee on Health. In closing, let me say that we have an opportunity to actually make the system better. Better benefits design is one thing, but I think also procurement, which the military knows very well, and we at GE do, is important. Now the DOD has been a Leapfrog member, as far as I know they haven't included that language in their contracts with health plans, and I would encourage that as a way to get things better. Thank you.

[The prepared statement of Dr. Galvin follows:]

PREPARED STATEMENT BY DR. ROBERT S. GALVIN

Senator Graham, Senator Nelson, and distinguished subcommittee members, I appreciate the opportunity to share with you today how leading employers in the private sector are addressing the problem of rising health care costs. My name is Robert Galvin, and my title is Director, Global Health, for General Electric (GE). In this position I am responsible for the design, operations and financial performance of the health benefits GE offers its employees, family members, and retirees as well as for the overall health of this population. Our population totals about a million people with an annual expenditure exceeding \$2 billion.

The challenges that the Military Health System (MHS) and a company like GE face in addressing health care costs are actually quite similar, outside of the direct care you provide. We both have highly trained workforces and keeping them healthy is critical for the optimal functioning of the operation; also, despite our relative sizes, rising health care costs represent significant pressure on our budgets; and third, both of us face the daunting challenge of trying to restrain excessive health care costs while not alienating our workforces or delivering them a less-than-outstanding health benefit in the process.

Let me say at the outset that we have not found a "silver bullet" to solve these challenges. What we have found is that a combination of flawless execution of purchasing basics plus a willingness to be innovative, using purchasing clout to address fundamental problems in our health care system, yield the optimal results. Probably

our most important learning is that because tough decisions are often necessary, and health care is always 'personal,' a sense of trust between those making decisions on benefits and those who use the benefits is critically important. We have learned that constant, candid communication is the key—and that when we believe we have communicated enough, we are probably only half the way there.

In my testimony today, I will focus on issues pertaining to the actual management of costs from the point of view of the purchaser. Other panel members will focus on the broader policy issues and trends facing the U.S. health care system or the actual details of the Military Health System.

Health care costs are rising rapidly today for many reasons. Employers find it useful to distinguish between those causes over which we have little control, e.g. increased costs due to advances in technology and an aging population, and those over which we believe sound management practices can have an influence. Two areas have the biggest impact.

(1) Benefit Design

(2) Using Procurement to Address Waste in the Health Care System

Although several other areas are important, e.g. population health, financial controllership, etc., due to my limited time today, my focus will be on the two aforementioned topics.

BENEFIT DESIGN

Designing the health benefit is a very important function. At GE, our philosophy is to: (1) protect people from the financial consequences of catastrophic illness; (2) offer coverage for medical services that are evidence-based, including preventive services, and to (3) maintain a reasonable level of cost sharing. We monitor our design in two ways: we perform annual satisfaction surveys to make sure we are meeting the needs of our employees; and we use an outside benefits consulting firm to benchmark the value of our design. Because we operate in very competitive markets, we need to offer a rich enough package to attract and retain employees but not so rich that we put ourselves at a competitive disadvantage with respect to our cost base.

An unintended consequence of having too rich a benefit package is that beneficiaries will drop other coverage available to them and preferentially choose the richest plan. Several large employers have now added a substantial fee for employees who could get other coverage, e.g. through a spouse, but choose to go with the richer plan offered by the large employer. The richness of your TRICARE for Life plan, though designed with the best intentions, could suffer from this unintended consequence.

Cost sharing is a key feature of health benefit design. Benchmarking data show that for most large employers, the desired split between company and employee payment is 70 percent/30 percent. This means that, overall, the company pays for 70 percent of the bill and the employee pays the other 30 percent. Having a reasonable amount of cost sharing is critical because there is well-accepted evidence that the demand for health services is elastic: very low payments by consumers lead to predictable increases in the amount of services used. On the other hand, higher payments lead to the use of fewer services, and some of the avoided services may have been necessary ones. It is not in anyone's best interest for these services to be reduced. Finding the right amount of overall cost sharing is an ongoing challenge.

It is worth noting that those employers who have a very low level of cost sharing are the ones facing the greatest problems with health care increases.

Although increases in cost sharing are never enthusiastically received, most companies devote significant resources to educate employees about rising health care costs and to explain why a reasonable amount of cost sharing is, indeed, reasonable. These companies have found that with the right explanations, their workforces are willing to accept reasonable changes.

ADDRESSING WASTE IN THE HEALTH CARE SYSTEM

A series of startling findings about the quality and efficiency of the health care system have emerged over the past 5 years. Experts from the Institute of Medicine (IOM) and the RAND Corporation have discovered that:

- Overall, adults receive only about 55 percent of recommended care;
- Unnecessary procedures and services accounts for over 30 percent of health spending; and
- There is wide variation on performance between doctors and hospitals.

The quality shortfalls have real consequences: the IOM found that up to 100,000 preventable deaths occur in our hospitals annually. Looking at just the waste, what

this means to a company like GE is that several hundred million dollars may be spent on unnecessary services. So even with a state-of-the-art benefit design, we are still spending a lot of money unnecessarily. If you apply the same percentage to the annual spend of the MHS, you will get a very high number.

Why is there such waste and variation in quality in our health system, long lauded as “the best in the world?” A series of papers published by the Institute of Medicine over the past decade concludes that there are multiple reasons for our system performance. For purposes of today’s testimony, let me focus on one of these: the fact that those who purchase health care have not demanded more and have not held the system accountable for what it delivers.

The IOM recommended that purchasers of health care use their buying clout to drive changes in two areas: first, transparency, i.e. pushing for the public release of performance measurement of doctors and hospitals, and second, payment reform. One of the significant changes over the past decade is that metrics have been developed that can measure quality at the level of doctors and hospitals. While it is true that these measures are still being perfected, most private sector employers believe that they are accurate enough for public release. Although there is little scientific data to cite, it is common sense in the business world that what is measured is managed, and that making public the performance of doctors and hospitals will spur improvement. Health services experts have continuously demonstrated that there are significant differences between doctors and hospitals in how well and how efficiently they deliver medical care. Our analysis shows that in every major market that GE has employees the same level of quality is available at prices that differ by 30–40 percent. Our data shows that only 35 percent of our hospital admissions occur at hospitals that score highest on both cost and efficiency. When we ask our employees, over 80 percent say they want this kind of information and will use it to make decisions about who to see and where to go for treatment.

Our payment system to doctors and hospitals is such that reimbursement is divorced from performance. In Medicare hospitals that perform superbly at a specific procedure are paid identically to those with much lower performance. The same is true for doctors. Again, although there is no clear scientific proof that paying for performance will increase quality and efficiency, it is a cardinal rule of procurement that you get what you pay for. Several large employers have developed a program called Bridges-to-Excellence, which rewards physicians who demonstrate the highest quality. Although researchers are currently evaluating this program, actuarial models predict substantial savings for employers and significant bonuses for high-performing physicians.

GE believes that there are substantial savings available from making performance available to the public and changing the payment system. The Pacific Business Group on Health, a private sector purchasing coalition based in California and representing 3 million covered lives, reported on research findings which showed that up to 17 percent of premium could be saved if employees and family members chose to see those providers with the best performance scores. Actuarial modeling in the Medicare program, and presented in testimony at recent hearings at the Way and Means Subcommittee on Health, suggests that with relatively little movement of patients to high-scoring doctors and hospitals, savings of 3–4 percent in the Medicare program are possible. These themes of transparency and pay-for-performance are strongly supported by Mark McClellan, CMS Administrator, as well as by Med PAC.

How would health care purchasers go about catalyzing this kind of change? The answer: through the procurement process. Several years ago, a number of private and public sector purchasers formed the Leapfrog Group, now 150 members strong, to bring about this kind of change in health care purchasing. The Leapfrog Group’s strategy is for each of its members to insist on transparency and pay-for-performance in its contracts with health plans. If enough purchasers include this language in their contracts, health plans will then change their contracts with doctors and hospitals, insisting on data release and paying for performance. Though the Department of Defense (DOD) has been an ex-officio Board member of Leapfrog, TRICARE has not included the aforementioned language in its health plan contracts.

The findings on waste and variations in quality refer to the private sector health care system. The MHS has its own doctors and hospitals, and I am not aware of data related to their performance. However, I am aware of the performance data from the Veterans Hospital Administration (VHA) health system, which has transformed itself over the past 10 years into a system that produces the highest quality of any system in the United States. The VHA outperforms the private sector delivery system consistently by 15–20 percent on quality measures and probably by that much on efficiency. In the absence of the kind of culture change and investment in information technology that the VHA has undergone, it is unlikely that the MHS delivery system performs as well. However, to the extent that the MHS commits

itself to VHA-level improvement, or that military personnel use the VHA health system, it is likely that substantial savings, and improvements in quality, are possible.

SUMMARY

In summary, the issue of health care costs is of great importance to private sector employers. The Human Resource Policy Association, the trade association representing the Senior Human Resource professionals for the largest 200 companies, has made healthy care its number one priority. This Association is promoting the practices I have outlined in my testimony today.

The Military Health System and GE face many similar challenges. Although state-of-the art benefit design, aggressive procurement and working with the delivery system to improve value has not solved the health care cost problem, it has certainly made health care more affordable and arguably has helped improve care. Given TRICARE's size, if it were to adopt the Leapfrog health plan language and implement the Bridges-to-Excellence program, I believe that the DOD could not only impact its own health costs, but contribute substantially to the improvement of the entire U.S. health care system.

Thank you for asking me to be with you here today.

Senator GRAHAM. Thank you very much.

Ms. Hosek.

STATEMENT OF SUSAN D. HOSEK, SENIOR ECONOMIST AND CO-DIRECTOR CENTER FOR MILITARY HEALTH POLICY RE- SEARCH, RAND CORPORATION

Ms. HOSEK. I, too, am honored, and it's a pleasure to be here this afternoon. I've been at RAND for over 30 years, and during all that time, I spent at least part of my time studying the military health system. It's really astonishing to me to see the changes that have occurred over that period. Dr. Chu mentioned the program started out as space-available care and I came onto the picture as an observer and a student some time after that. But, it's really remarkable the changes that have occurred.

I'm going to talk about three issues this afternoon. I'm going to make some comments on cost, and the cost trends that the DOD is experiencing. Then I'm going to talk about benefit design. I'm going to discuss it in the specific context of TRICARE and focus, in particular, on under age 65 retired beneficiaries, where I think there may be some opportunities for some cost savings.

Finally, I'm going to talk about the organizational structure. Various people, but especially Dr. Galvin, has talked about better management of the system and that the organization of the military health system today is probably not ideal for carrying out those kinds of management initiatives in the future. I will come to that at the end of my talk.

We've heard a lot about cost growth. One of the exercises I did in preparing for this presentation was to take a look at the Congressional Budget Office's information on costs in the military health system, going back over the past 15 years, and compared those with the civilian sector. In both cases what you see is a 4-percent per year increase after adjusting for inflation, and that adds up pretty quickly.

What's interesting about it is that the U.S. health care system has experienced that kind of real cost growth for more than five decades, so this has been going on for a long time. It's pinching ever harder, but this is not a new phenomenon. As others have mentioned, the military health system is simply experiencing the

same cost growth as everyone else, not just in the United States, but in other countries as well.

Now, as you've heard, civilian employers have been reacting to this cost growth. If you look at all civilian employers, you see a rather pronounced trend towards shifting higher fractions of health care costs to employees, and that's taken several forms.

One form is increasing premiums, increasing cost sharing, and importantly reducing or eliminating retiree health benefits, which was an important part of the military benefit. The result is that today TRICARE is a very attractive health plan compared to most employer health plans. As Dr. Winkenwerder mentioned, there's substantial evidence that the beneficiaries are noticing this, and that more of them are turning to TRICARE instead of an employer option for their health care.

There's a very obvious reason why every retiree under 65 who's working might prefer TRICARE to their employer plan, and that's the premium contribution. If you look at all employer health plans, and this information came from the Kaiser Family Foundation Survey that's done every year, there's an annual average contribution by the employee to enroll in the employee plan of over \$2,600 a year. TRICARE currently charges nothing for the extra, or standard, \$460 premium contribution for retirees, and TRICARE hasn't changed since the 1990s when the program was implemented. We don't actually know how many retirees have given up employee health coverage in order to use TRICARE. That's something that I know that Drs. Chu and Winkenwerder are quite interested in finding out more about. But we can get an idea, looking at some relatively recent survey data on military retirees. I focused on those who are under 65 and working full-time.

Now, if they weren't military retirees and didn't have access to TRICARE, we know from other studies that almost all of these people would be covered by employer health insurance. Yet 35 percent of them are paying the \$460 to enroll in TRICARE Prime and fully two-thirds of them are getting at least some of their care from the military health system. So even this group of people whom you might expect to be most reliant on employer plans, are in fact, increasingly reliant on TRICARE, and it's easy to understand why.

Now, the problem is, this results in a situation where there's a high cost to DOD, but most of the benefit is not accruing to the beneficiary, it is, in fact, accruing to the employer. Dr. Galvin may be benefiting from some of this. Now, what can we do about this? Well, one obvious solution is to increase the TRICARE premium contributions and make them more comparable, but that would be a huge benefit cut, and I suspect it would be rather difficult to do, especially right now. There may be other ways to approach this.

Dr. Galvin mentioned that they actually penalize employees for using their plan when they could be using another one. What I'm going to suggest you think about is the opposite of that, which is compensating military retirees under age 65 who participate in their employer health plan for the out-of-pocket costs that they face in those plans. This could take the form of a Health Savings Account, and so we come back to that idea. It could also take other forms.

Senator GRAHAM. Excuse me, if you're under 65 and you're working with GE, you would pay what? If you would go with GE?

Ms. HOSEK. You would set up a Health Savings Account, so these would be presumably tax-exempt dollars, and the retiree would use those to cover their out of pocket costs in their employer plan. Now, this would be a voluntary option, so they could stay in TRICARE or they could stay with their employer plan, but they would get some coverage for their out of pocket costs. It's just a way of using a carrot approach.

Senator GRAHAM. I'm sorry, go ahead.

Ms. HOSEK. There are other benefits you could offer. Currently there's no benefit for long-term care, and that's one option. Another would be to increase the retirement annuity slightly so there are a number of ways you could do this. The basic idea, though, is to essentially make a deal with the retirees to help them out with their costs.

We don't have enough information to figure out today exactly what an option would look like, how many retirees would, in fact, be interested in it, and whether the department would really save all that much money. The reason for being worried about the cost savings is that if you have a benefit like this, it's also going to be used by the retirees who currently are using their employer health plan, and not using TRICARE at all. So, you have some people who are using TRICARE instead of their plan and you're going to make money on them, but then you're going to lose money on the people who are going to do the opposite.

So the question is, where do you come out in the end? There seems to be enough potential here, especially if the projections about growing reliance on TRICARE are correct, that it would be worth some effort, I think, to figure out whether this would work.

There are some other changes that could be made in benefits, one that has been brought up many times in the past is charging a clinic fee for use of military clinics. Visits to military clinics are currently free. Retirees pay \$12 per visit if they're in Prime and use a civilian provider. The idea would be just to take that \$12 fee and also implement it in the military facilities, at least for the retirees. As it turns out, some of my colleagues that ran into this study fairly recently that looked at the civilian HMO that implemented a similar fee, and indeed there's a decrease in utilization, but the cost savings were actually relatively modest.

Whether that would really be an important change I don't know. The area where there is more promise is in the cost sharing for pharmaceutical drugs. TRICARE charges \$3 for a generic drug, and \$9 for a brand name drug. If the beneficiary goes to the retail pharmacy network, a typical employer health plan charges more like \$10 for the generic drug and \$20 for the brand name drug. Others of my colleagues, as it happens, have looked at what happens when you increase pharmaceutical co-pays by about that order of magnitude, and they found that pharmaceutical costs are reduced by one third, which is a very substantial savings.

Much of the decreased utilization, but not all of it, is for drugs that have very close substitutes over the counter, such as antihistamines, and pain relievers. So this may be a promising option. I would point out that if that change is made, and not implemented

for military pharmacies, what's going to happen is, a lot of people who have been going to the retail pharmacies will try to go to the military pharmacies, and you will save less.

Senator GRAHAM. Could you finish your statement in about 3 minutes, do you think?

Ms. HOSEK. I can. Then you would save more. I would just like to make some very brief comments about the organizational changes. We've heard a lot about possible management initiatives that could be cost savings. Right now the military system is operated through four chains of command. We did a study a few years ago where we looked at the civilian sector and tried to draw lessons for the military system. What we found is that the military system lacks the clear lines of authority and accountability that all leading civilian health care organizations have. So we drew a number of specific conclusions about how the system might be reorganized so that it would hopefully be better able to manage TRICARE. We paid a little attention to readiness, but not a lot, in that study. There is consideration now of establishing a joint medical command, and we took a look at that. That may be a good idea, but unless other changes are also made, it is unlikely that a joint medical command will be sufficient for the purpose, and that's all I have.

[The prepared statement of Ms. Hosek follows:]

PREPARED STATEMENT BY SUSAN HOSEK¹

Chairman Graham and distinguished members of the subcommittee, thank you for inviting me to testify today on present and future costs of defense health care. It is an honor and pleasure to be here.

My testimony will briefly discuss cost trends in Defense health care and then focus on two areas in which the Department of Defense (DOD) might consider making changes: (1) TRICARE benefit design and (2) organizational structure of the Military Health System (MHS).

DEFENSE HEALTH CARE COST TRENDS

Through TRICARE, DOD provides a comprehensive health benefit to Active-Duty personnel and their dependents. With the addition of TRICARE for Life (TFL), this is now a lifetime benefit for those who make the military a career. A continuous benefit is now being offered to reservists who have been called to Active Duty since September 11, 2001. The health benefit grew out of a policy of granting dependents and retirees eligibility for care in military treatment facilities (MTFs) when they had space available after caring for Active-Duty members. With the establishment of an employer-based health system in the U.S., a defined health benefit replaced space-available access for under-65 beneficiaries and CHAMPUS was established to finance any care military providers couldn't handle. TRICARE modernized the delivery of the benefit by integrating management of MTF care and CHAMPUS-financed civilian care by adding an HMO option (Prime) and a PPO option (Extra) to the Standard fee-for-service option, partnering with civilian health-care companies, and improving access to care. Today, TRICARE compares favorably with civilian health plans on many measures, and military members clearly consider it to be an important element of their compensation package and a visible marker of the support and appreciation for their service to the Nation.

Like all public and private payers, DOD has experienced unrelenting, significant growth in the costs of its health benefit. DOD's inflation-adjusted per capita health-

¹The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to Federal, state, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

care costs increased just under 4 percent per year from 1988 to 2003 (excluding costs for TFL). This is approximately the same real rate of increase experienced in the civilian sector during the same 15-year period. Moreover, this has been the long-term rate of increase in health costs for the past 5 decades.² So DOD's health system is simply on the same path as the U.S. health care system overall.

Can anything be done to curb cost growth in the future? Civilian employers have resorted to benefit cuts to control costs, shifting some costs to their employees and hoping that higher cost sharing will induce lower spending. Economic research has consistently shown that increases in health costs are offset by lower wages in the civilian labor market.

In contrast to the private sector, DOD has expanded its benefits in recent years, eliminating almost all cost sharing for Active-Duty personnel and their family members if they are enrolled in Prime and adding TRICARE for Life to supplement Medicare coverage for beneficiaries over age 65. As I describe below, TRICARE today is a more attractive option than employer health plans for most of the beneficiaries who are eligible for both DOD and civilian employers' health plans. Most of these beneficiaries are military retirees who have a second career (and their spouses), but some Active-Duty spouses are also eligible for civilian-employer health benefits. If current trends continue, DOD risks becoming the primary insurer for all of its beneficiaries, picking up an even higher share of costs that would otherwise be covered by employer health plans. When costs merely shift from employers to DOD, the cost to DOD increases but there is little change in the value of the benefit to servicemembers.

Health services researchers agree that the long-run trend toward higher health care costs largely reflects advances in medical technology, but there is little evidence on the health payoff from these advances. A recent RAND study found that approximately half of the health care delivered in the U.S. is inappropriate.³ Medicare and other major payers are exploring new mechanisms for targeting health care dollars on a more appropriate mix of services. DOD's current organizational structure, with its parallel management structures in the Office of the Secretary of Defense and the Services, is not ideal for undertaking this kind of complex health management initiative.

DESIGN OF THE TRICARE BENEFIT

Overall, TRICARE benefits compare favorably with benefits in private-sector plans. Cost sharing is about the same for downtown office visits and MTF care is free; TRICARE premiums and TRICARE pharmaceutical cost sharing are lower. For beneficiaries who are eligible for employer benefits, the big difference is in the premium contribution required for TRICARE versus their employer's plan. Differences in beneficiary cost sharing for covered services are smaller and the services covered are fairly similar.

The average annual premium contribution for family coverage in employer plans was \$2,661 in 2004, and there was little difference between HMO and non-HMO plans. TRICARE requires no premium contribution, except for retirees who elect to enroll in Prime, the HMO option.⁴ Family coverage cost them only \$460 in 2004—the amount established when TRICARE was implemented almost a decade ago. This difference in premium cost will continue to grow over time unless TRICARE premiums are increased.

Undoubtedly as a result of this “premium gap,” relatively few TRICARE beneficiaries employed in the private sector are covered by employer health plans. Currently, DOD surveys do not support estimates of how many beneficiaries are foregoing employer insurance for which they are eligible. But we can infer that this behavior is probably widespread by looking at military retirees who are under age 65 and working full-time. In 2002, 72 percent of these retirees worked for employers providing health insurance. Among those with access to an employer health plan, 35 percent paid to enroll in TRICARE Prime and 62 percent sought care through some TRICARE option.

²Growth in Medical Spending by the Department of Defense, Congressional Budget Office, 2003; Cutler, D.M., M. McClellan, et al., “What Has Increased Medical-Care Spending Brought?,” *American Economic Review*, Vol. 88, No. 2, Pg. 132–136, 1998.

³McGlynn, E.A., S.M. Asch, et al., “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*, Vol. 348, No. 26, Pg. 2635–2645, 2003. The study evaluated the quality of care for a random sample of adults living in 12 metropolitan areas. It measured performance on 439 indicators of quality of care for 30 acute and chronic conditions as well as preventive care. Overall, participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care.

⁴The new TRICARE Reserve Select program requires a premium contribution of \$2,796.

Focusing on families, when a military beneficiary gives up employer insurance and uses TRICARE, the employer saves about \$7,200 a year and the employee saves over \$2,000. DOD assumes both costs. So much of the DOD benefit accrues to the employer instead of the retiree. Eliminating or reducing the TRICARE premium gap for under-65 retirees and dependents would induce more retirees to participate in their employer plans, but it would represent a significant benefit cut and lead to the possibility that some military retirees without access to employer benefits would become uninsured.

A more promising approach is to offer a new benefit that retirees can choose in lieu of TRICARE and use to cover premiums and out-of-pocket costs in employer plans. This new benefit might take the form of a Health Savings Account. Making a simplistic calculation, DOD can cover the \$2,000 premium contribution and make \$7,000 on the exchange. But some retirees who forego TRICARE now will take advantage of this new benefit, offsetting at least some of the cost savings from prior TRICARE users. There are other benefits that could be offered to induce beneficiaries to enroll in and rely on their employer plans. More information is needed to determine whether any of these approaches would realize significant savings, how retirees would react to the idea, and how to design the most cost-effective approach for both DOD and retirees. The potential of this general approach is such that an investment in information and analysis is warranted.

As I indicated earlier, out-of-pocket costs for getting care from civilian providers are similar in TRICARE and other employer plans. For example, the typical HMO plan charges a \$15 visit fee whereas TRICARE Prime has no fee for active-duty dependents and a \$12 fee for retirees and their dependents. Most non-HMO employer plans also rely on a visit fee—typically \$20 for a provider under contract to the plan—which is likely to be just below what the 15–20 percent cost sharing costs beneficiaries in Extra.⁵ But TRICARE only charges for care delivered by civilian providers; MTF care is free of charge. Introducing a copayment for MTF visits has been suggested before and while it would reduce outpatient utilization, overall cost savings are likely to be modest.

However, employer plans typically charge twice what TRICARE does for prescription drugs. TRICARE charges \$3 for a generic drug and \$9 for a brand-name drug, whereas employer plans typically charge \$10 and \$20, respectively. Also, as with other services, many military beneficiaries have access to free prescriptions in the MTFs. A recent RAND study showed that people are highly responsive to the price they pay for prescriptions.⁶ Updating prescription copayments to employer-plan levels would likely lead to noticeable cost savings in TRICARE, provided that the copayments applied to prescriptions filled by the MTFs, not just civilian pharmacies.

To summarize, the TRICARE benefit is more attractive than the benefit offered by most civilian employers and, as a result, many retirees appear to be relying on TRICARE instead of their employer's plans. Rather than reduce TRICARE benefits to private-sector levels, it may be possible to induce retirees to take full advantage of any employer benefits for which they are eligible by offering to offset their higher out-of-pocket costs. This would ensure that DOD's spending on health care benefited its beneficiaries, rather than their employers. Some modest changes in cost sharing for care may also be worth considering.

ORGANIZATION OF THE MILITARY HEALTH SYSTEM

The second area where changes could impact trends in costs is the organization of the Military Health System. My comments on organization are based on a 2001 RAND report on creating a joint medical command and organization of the military health system more generally.⁷ This study drew on organizational models from the civilian sector and within the DOD to develop and assess organizational alternatives. Although we paid careful attention to the evidence on effective organizational approaches, we also considered how the coordination required between oper-

⁵Information on employer plans comes from Employer Health Benefits: 2004 Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust, 2004.

⁶Increasing the price from \$5 to \$14 for a generic drug and from \$10 to \$20 for a brand-name drug reduced spending by 33 percent. The largest decreases were for drugs that have close over-the-counter substitutes; higher prices caused smaller reductions in the use of drugs that don't have substitutes and are important in controlling chronic illness. Joyce, G.F., J.J. Escarce, et al., "Employer Drug Benefit Plans and Spending on Prescription Drugs," JAMA, Vol. 288, No. 14, Pg. 1733–1739, 2002; Goldman, D.P., G.F. Joyce, et al., "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," JAMA, Vol. 291, No. 19, Pg. 2344–2350, 2004.

⁷Hosek, S.D. and G. Cecchine, Reorganizing the Military Health System: Should There Be a Joint Command?, RAND Corporation, MR-1350–OSD, 2001.

ational medical support and providing TRICARE services might be accomplished under the alternatives we identified.

Consistent with basic principles of organizational design, civilian health care organizations consolidate authority and responsibility in single market managers, who report through a regional chain of command to corporate management. Since experience has shown that there can be a conflict of interest, management of the health plan is separated from management of the providers when they are not separately owned.⁸ Accountability is maintained through the strategic planning and evaluation processes, which set specific financial and non-financial goals. Management information systems are tailored to support planning and evaluation, and strong incentives are established and aligned with goals.

TRICARE management has taken steps that reflect these standard private-sector practices. However, we concluded that a single chain of command for TRICARE management, separate from the MTF command structure, would create the clear lines of authority and accountability that characterize the private sector. Arguably, the same principles might apply in operational medicine as well, but our study did not investigate the management challenges associated with the readiness mission. We did consider how readiness considerations might alter our conclusions about organizational effectiveness for the benefits mission (TRICARE).

We identified four alternative organizational structures that consolidate authority over some or all of the system. The first alternative would consolidate TRICARE authority within the current structure by modifying resource management and accountability. The resources used to deliver care to TRICARE beneficiaries would flow through TMA to a group of local market managers, who would reimburse the Services for MTF care and the contractors for civilian care. TMA and its local market managers would be accountable for overall TRICARE outcomes and the Services would be accountable for the care they provide. The other three alternative structures establish a joint medical command, but they differ in how they structure the command. One establishes a joint command over the organizational structure I just described. Another maintains three Service component commands, each responsible for medical readiness activities within its Service and for managing all health care provided for its defined population. TMA would be largely disbanded under this scheme. A third joint command alternative organizes two joint chains of command, one for readiness and the other for TRICARE. The MTFs would be managed through the TRICARE chain. All of these organizational schemes, including the current one, require development of an efficient mechanism for shifting personnel and other resources between readiness and TRICARE.

We could not be certain which of these alternatives would out-perform the others. But we could conclude that any of the alternative organizations we identified, which would consolidate authority over TRICARE resources and establish clear accountability for outcomes, should out-perform the current organization, which lacks these characteristics. We further concluded that establishing a joint medical command over the current structure, without making these other organizational changes, likely would not be as effective. In short, we concurred with at least a dozen other major studies of military health care organization, conducted over six decades, that more consolidated management would be advantageous but we also recommended a package of changes that would reflect best organizational practices.

CONCLUSION

Outside TRICARE for Life, the long-term trend in Defense health costs reflects the trend in health costs in the U.S. and many other countries. In light of the persistence of this trend over many decades, it can be expected to continue into the future. But there are potential opportunities to shift the cost line downwards. Asking beneficiaries to pay when they get care would lead to decreased utilization and costs, but high cost sharing would also represent a benefit cut—a difficult action to contemplate now. Adding new benefit options that would offer beneficiaries the option of using employer health plans without incurring substantially higher premium costs could result in gains for both beneficiaries and DOD. As the U.S. health system continues to search for ways to curb costs and/or improve health outcomes, DOD should reconsider its health care organization so that it can readily adapt new approaches and create some itself.

Thank you for the opportunity to contribute to the debate regarding Defense health care costs. I am happy to answer questions from the subcommittee.

⁸In the Military Health System, TRICARE is the health plan and the MTFs are providers.

Senator GRAHAM. Thank you all, that was very informative. To pick your brain quickly, the bottom line is our co-cost sharing aspects of TRICARE have virtually been flat. We have a unique problem in the sense that there's a promise being made to retirees about health care. It seems to me that we're going to have to look at re-designing that promise in the future, and without looking at that, this is just going to continue to get out of hand.

Do all of you agree from what we've heard today that the efforts for best practices, that they're implementing as far as administration, you get paid more if you return phone calls, if you do things expeditiously, that there could be additional savings if we went to the best practices, in terms of actually delivering health care?

Dr. BLUMENTHAL. I certainly think you could get more value for your dollar and I think you could probably save some administrative expenses, so you would have a more satisfied clientele in the military health system. The implementation of a best practice is certainly much to be sought in the clinical side, and there are some areas where we have pretty clear knowledge of what to do and we can do it a lot better, so I think we could make some progress. It's not 100 percent sure you'll save money by doing things right, a lot of people hope and expect that, they ought to do them right, just because it's the right thing to do, but I don't think you could necessarily be assured that you will fight your way out of this cost problem by paying for performance.

Dr. GALVIN. I concur with that. I think in the first generation that we thought about this it was just best practices. I think we now recognize that sometimes doing it right saves money and sometimes it doesn't, but we recognize that doing it right and being the most efficient at it always saves money, versus the other. So all of our paid for performance is around not only including best practice, or doing the right thing, but that you have to be the one who's doing it the most efficiently. I think you have to integrate efficiency into the quality and then you do save money.

Ms. HOSEK. I would like to just issue a caution here. The military system has two different pieces. It has the in-house system and it has the contracted care, and I think it is quite a challenge to figure out how to get both of those lines up and marching in the right direction. The TRICARE contracts can certainly put in pay for performance kinds of measures, but you also have to pay attention to what's going on in the direct care system as well, and make sure that the two are well-coordinated.

Senator GRAHAM. Health Savings Accounts (HSAs) have been mentioned several times. What is the panel's general consensus about a HSA component?

Dr. BLUMENTHAL. Let me talk about this from the standpoint of the chronically ill population which, as I indicated, accounts for a lot of the escalating costs and a lot of the absolute costs. Think about somebody who has high blood pressure and heart problems. They spend a lot of money every year on health care and they're going to blow through whatever their \$1,000, \$1,500, \$2,000 HSA is every year. So, it doesn't make any sense for them to purchase it. I think it is a good buy for a relatively healthy population, but I don't think it's a solution to the problems that face our chronically ill population.

Dr. GALVIN. We disagree on that one. Let me be clear, first of all, I'm not speaking on behalf of GE, we negotiate our benefits through collective bargaining, we do not have HSAs and if we ever were to get them we would do it through bargaining, so I just want to be clear.

Personal opinion, though? I think HSAs have a lot of promise, I think they have some issues when it comes to the chronically ill, and I have already seen some developments in the market that these kinds of plans are going to mature and get better and better as the market works on them. I think HSAs, with the amount of information we have on quality and efficiency today, are not going to be nearly as good as HSAs with the kind of information that people can make the choices that Senator Coburn was talking about with real data. So, I think we need to do those at the same time.

Ms. HOSEK. With the HSA, the military has an opportunity to possibly look at some options there that would operate a bit differently, perhaps, then some of the plans that are out there and elsewhere, rather than leaving the big gap between the HSA and the catastrophic insurance that Dr. Blumenthal is concerned about. It may be possible to integrate an HSA option with other aspects of the military compensation system, so that you, again, use the carrot approach to induce people to save money on their health care costs, rather than using the approach of taking it out of their pocket if they don't.

One way, for example, is to fully fund the HSA, but then allow them to roll the money over, at least on some partial basis, to other uses, and that would provide the incentive to save money without putting people at risk for large out-of-pocket expenditures. There are a lot of things you may be able to do. It's a very flexible approach, potentially, so there may be ways to adopt it.

Senator GRAHAM. Senator Nelson?

Senator BEN NELSON. Thank you, Mr. Chairman. I'm intrigued by many of the comments that would show a common trend. Ms. Hosek said that approximately half of the health care is inappropriate, is that accurate?

Ms. HOSEK. I think I was referring to exactly the same study Dr. Galvin was.

Senator BEN NELSON. Dr. Galvin noted 30 percent of unnecessary procedures, and Dr. Blumenthal, you referenced the fact that there were huge differences in the cost of health care, depending upon what region you may find yourself in. If we were to close the gap in each and every one of those situations, how would we do it? I'll start with you, Dr. Blumenthal. How would we go about closing the gap, reducing the differential, the unnecessary procedures, and inappropriate care?

Dr. BLUMENTHAL. Well, let me put the arithmetic aside, because I think that 30 percent inefficiency in our system is due to administrative cost, and now 30 percent is due to inappropriate care.

Senator BEN NELSON. That would be appropriate to come back and identify that as well.

Dr. BLUMENTHAL. We could get down to zero for our health care budget pretty soon, which would be a great buy. But, I think that we've struggled with exactly this question for decades. This is the

critical question in health care for the military and for the entire industrialized world. How do you decide what makes sense to pay for and what doesn't? How do you not infringe on the patient/physician relationship, and not alienate the patient and alienate the physician? The history of managed care is a history of infringing on the freedom of choice.

Senator BEN NELSON. Well, even in western Nebraska we found it important to have people manage to find care, because of the availability of it, and the accessibility as well.

Dr. BLUMENTHAL. So, I think you have to put incentives in place at multiple levels. I'm not against patient cost-sharing. I think that makes some sense. I suspect the military has gone too far in taking the patient out of the equation. I think you have to have physicians and health care providers also have, as they say, some skin in the game, and pay them in some way that is consistent with the appropriateness. Stated differently, the quality of the care that they provide. I think the health insurer has to play a role, and the employer has to play a role, in this case you're talking about TRICARE in terms of creating the systems that provide the information the doctors need and the patients need to make correct choices. I think those are the areas in which we're working right now, but I would be misleading you if I contended that we knew exactly what would work, because we are struggling at every level to make this happen.

Dr. GALVIN. I agree, it is a complex question, and there is no clear answer, but I think it is true on its face that without transparency, without people—even their own doctors and hospitals—knowing how well they're doing, it's impossible to think that we get better. When I was in practice, and it's still true today for most physicians, we didn't know how many diabetics were in their practice. When a drug gets recalled we didn't know who's on it and who isn't on it. I have a back problem now, and I wanted to go seek care, and I'm pretty sophisticated about this stuff, but I couldn't figure out where I should go for this. I think transparency and public release of understandable information is a threshold issue. I think unless we cross that one, we can't even get close to it. Then it gets more complicated. I don't think transparency is complicated, I think that is a necessary condition.

I think it is incentives and rewards. At GE we think pretty concretely "you get what you pay for" and if you're going to pay the same to do a fantastic job and the same to not do a very good job, it's hard to imagine that we can get on the road to getting the best practices we want. I agree with Dr. Blumenthal, they're not the answer, but I think they're important steps on the path.

Ms. HOSEK. I'm an economist and so I do believe in incentives, and I don't believe in regulation, which means that I think the pay-for-performance is a promising approach. It's not going to be easy to figure out how to do that, especially across the board for all the different kinds of care that are provided, and furthermore to keep it up to date, so that you're not paying for yesterday's performance, but you're paying for the right performance, based on current information. But, I think that is probably the promising way to go, and there are ways, I believe, of implementing a comparable system within a system like the military health care.

Again, coming back to the direct care system, when you don't reimburse providers for providing care, you pay them a salary, but still, there are ways of rewarding those providers, and acknowledging their performance when they do well. So I don't see any reason—in fact, I know that at RAND, because we do a lot of health care research and we do a lot of military research—we've been intrigued for years by the opportunity to take advantage of the military health system to figure out how to do some of these things.

Senator BEN NELSON. Well, as it relates to the economics of the military health care system versus private and outside non-military, is there any differential there related to medical liability costs?

Ms. HOSEK. Yes, I think there actually is. Obviously the government is liable, but the liability is much less. Actually, military beneficiaries don't sue at anything like the rates that other people do. So, Dr. Winkenwerder, I'm sure, knows much more about that than I do. There are other restrictions, particularly in state law that don't apply to the military and licensing laws and that kind of thing. When I first came to RAND, I worked on physician assistants. The military was trying to figure out how to do it with active physicians, so they turned to physicians assistants and they were among the very leaders in the country in developing training programs and using those people in their clinics. So they've shown they can do this kind of thing.

Senator BEN NELSON. Dr. Winkenwerder should be very much relieved that his problem will be lesser for him than it will be to solve the rest of the health care problems without medical liability issues as well.

Thank you, Mr. Chairman.

Senator GRAHAM. Thank you all, thank you to the panel. At this moment, I would like to ask that testimony from the Reserve Officers' Association be placed in the record.

[The prepared statement of the Reserve Officers' Association follows:]

PREPARED STATEMENT BY THE RESERVE OFFICERS ASSOCIATION

The Reserve Officers Association of the United States (ROA) is a professional association of commissioned officers of our Nation's seven Uniformed Services. ROA was founded in 1922 during the difficult years following the end of World War I. The founders of the ROA believed America was vulnerable to return to its pre-war unpreparedness. When chartered by Congress in 1950, the act established the objective of ROA to: "... support and promote the development and execution of a military policy for the United States that will provide adequate national security." The mission of ROA is to advocate strong Reserve components and national security, and to support Reserve officers in their military and civilian lives.

The Association's 75,000 members include Reserve and Guard soldiers, sailors, marines, airmen, and coastguardsmen who frequently serve on Active-Duty, voluntarily or involuntarily, to meet critical needs of the uniformed services. ROA's membership also includes the U.S. Public Health Service and the National Oceanic Atmospheric Administration. ROA is represented in each State with 55 departments plus departments in Latin America, the District of Columbia, Europe, the Far East, and Puerto Rico. Each department has several chapters throughout the State and is further divided into regional chapters. ROA has more than 550 chapters worldwide.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers Association is a private, member-supported, congressionally chartered organization. Neither ROA nor its staff receive, or have received grants,

sub-grants, contracts, or subcontracts from the Federal Government for the past three fiscal years. ROA has accepted Federal money solely for Reserve recruiting advertisement in its monthly magazine. All other activities and services of the Association are accomplished free of any direct Federal funding.

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INTRODUCTION

In answering the call-up, some 475,000 Reserves have been mobilized cumulatively since the issuance President Bush's issued Executive Order 13223 on September 14, 2001, which authorized the activation of up to 1 million military reservists for the global war on terrorism.

Pre- and post-mobilization health care is being spotlighted with each wave of deployment. ROA thanks the Personnel Subcommittee for the chance to present testimony on behalf of the 1.2 million ready reservists most affected by medical readiness. Further we would like to thank each member of this committee for working with Department of Defense (DOD) and the associations to improve TRICARE coverage not only in quality but also in continuity; making pre- and post-mobilization coverage permanent, and also introducing TRICARE Reserve Select for most of those who have served in the global war on terrorism.

We commend the support that your committee has provided to the young men and women who are deployed overseas, and stationed at home. We also believe that comprehensive care of the dependents of these young warriors allow the members of our armed services to better concentrate on their jobs. Most important is your recognition that a continuity of health care needs to extend into the Reserve Centers and Guard Armories to better complete this coverage.

Health care readiness remains the number one problem when mobilizing reservists. Most Reserve component members shoulder the cost of their personal medical readiness. Because of the high cost of medical care, many Guard and Reserve members do not carry health care coverage. The Government's own studies show that between 20-25 percent of guardsmen and reservists are uninsured.

With a growing percentage of Reserve component members being recalled to multiple deployments, a continuum of health care is becoming as important as pre- and post-deployment coverage.

Health Care

The global war on terrorism is being described as multi-generational by the leadership in the Pentagon. It will be a protracted engagement, which overwhelms the resources of the active Services. To compliment the Active-Duty Forces, the Guard and Reserve have accepted the task of warrior on numerous fronts. Over 55 percent of our Guard and Reserve Forces have already been called to do battle.

The Reserve Officers Association believes that a continuity of health care for these young warriors and their families will allow the members of our armed services to better concentrate on their jobs, as the spouse who is left behind will better understand this benefit if it is unbroken. The side benefits will be a higher level of medical readiness, retention of Reserve component members, and an incentive for Active component members to transition in to the Reserve component at their end of contract.

Continuity of Medical Coverage

As this conflict is expected to be long term, and Reserve component members are expected to be mobilized multiple times, the importance of continuity of health care becomes increasingly important and should be emphasized, as it will impact Reserve component members and their families. If soldiers or marines are worrying about their families while in the battlefield, the costs to the U.S. military will be more than just health care coverage.

Pressures caused by higher health care costs have harmed recruiting and retention.

When leaving Active-Duty, the loss of benefits causes many prior servicemembers to concentrate on their civilian career to recover those benefits. While cash bonuses may be in the short-term enticement to join the Guard or Reserve, cash alone doesn't provide a family security in an environment of frequent call-up.

Guard and Reserve members are on call 24 hours a day, and are expected to meet the same physical, dental, and medical standards as their Active-Duty counterparts. Reservists are expected to pay for their own health club and medical coverage while in civilian status, where wages are growing slower than inflation. ROA believes the military standards to maintain physical readiness is a shared responsibility of both the DOD and the military member.

Health insurance coverage varies widely for members of the Guard and Reserve. Some have coverage through private employers, others through the Federal Government, and still others have no coverage.

The stress on maintaining a private-sector job and membership in the Guard and Reserves can be overwhelming. Add to this a job market where no longer are there "jobs for life," management is flexible and ever changing, employees are expected to change along with the company and its operating environment, and companies are not stable entities with mergers, acquisitions, and attrition resulting from increased global competition.

It's estimated that the average worker changes jobs 10 times and careers 3 times in a working lifetime. These changes in jobs occur every 2 to 3 years before age 30 and every 4 to 7 years thereafter. In between, gaps can occur in health coverage.

Job seekers are very receptive to relocating for the right position or benefits. Surveys show that 50 to 60 percent of job applicants are willing to move. This number increases to as high as 94 percent for younger, entry level job seekers.

Relocating to a new job disrupts Guard or Reserve continuity. Most will transfer into the Individual Ready Reserve (IRR) until their new life settles down, many never to emerge again.

The number of people willing to relocate drops to only 19 percent when there are family ties to the community. If the Guard and Reserve can create this sense of community it should encourage retention. A continuity of health care would help.

A continuity of health care can help build the sense of community between a Guard and Reserve member and the Reserves by providing stability. Roller coaster changes in family health care when a spouse changes Reserve status can be a traumatic and even confusing for family members. Enabling drilling members and their families to sign up for TRICARE would not only provide stability but also reassurance for the reservist when deployed.

Continuity Options

ROA recommends authorizing access to TRICARE on a cost-share basis, or premium cost-share for civilian health plans upon activation.

Option 1: Expanded TRICARE Access

Drilling Guard and Reserve servicemembers would pay an annual cost-share premium for TRICARE coverage for either themselves or their families. With activation of 30 or more days, and the government would assume all of the cost as it would for Active-Duty members. Once the de-mobilization process was complete, the drilling Guard and Reserve could return to a cost-share basis.

The TRICARE access option is consistent with the DOD's "seamless, integrated total force policy," as it would open TRICARE to G-R families and eliminates a "structural barrier" inhibiting true integration of the total force.

ROA believe families would better support a career in the Reserve component, if health care were provided as a benefit. Spouses would make reservists think twice before quitting the Guard or Reserve and losing this benefit.

Costs: a recent Government Accountability Office (GAO) report (GAO-02-829, Defense Health Care, September 2002, hereafter, GAO Report) estimated that DOD's cost would be \$7 billion over 5 years if reservists paid a premium similar to that paid by Active-Duty retirees under age 65 (TRICARE Prime).

Option Two: Payment of Premiums for Employer or Personal Health Insurance

Guard and Reserve family members are eligible for TRICARE if the members' orders to Active-Duty are for more than 30 days; but some families would prefer to preserve the continuity of their own health insurance. Being dropped from private sector coverage as a consequence of extended activation adversely affects family morale and military readiness and discourages some from reenlisting. Many Guard and Reserve families live in locations where it is difficult or impossible to find providers who will accept new TRICARE patients.

During both activation and during TAMP, DOD could contribute a premium payment that is not to exceed its TRICARE contribution. Payments could be made through direct deposit to employers or employers' health care insurers. The Guard and Reserve members' families would be able to continue with the employer health insurance without disruption, and the administering by DOD would be simply to cut a check. Congress has directed GAO to explore this option.

Health care is a key benefit. ROA surveyed the Fortune 500 employers, and found that if any benefit was provided it was health care continuation first. This shows how important it is. If our patriotic employers recognize this, so should DOD.

TRICARE Reserve Select (TRS)

Time and study has allowed ROA to recognize Congress' wisdom behind their creation of TRICARE Reserve Select. In creating a new form of TRICARE, they have also created a health care engine which can drive a continuity of health care.

The beauty of this new model is that the premium based Standard TRICARE can be modified. It provides a basic health care for a standard cost. Different beneficiaries can now be included with TRS offered at different cost share premium packages.

ROA recommends Congress explores cost-share coverage for:

- A. Unemployed
- B. Uninsured
- C. Drilling reservists
- D. Allowing gray-area reservists buy-in.

Concerns with TRS

1. Uniformed Service Employment and Reemployment Rights Act (USERRA)

If the member elects coverage under TRS then they may lose their USERRA protections.

USERRA allows Guard and Reserve members immediate re-enrollment in the employer's health benefit plan upon re-employment following Active-Duty longer than 30 days, irrespective of whether the employee reservist elected to continue coverage during activation. Further it doesn't permit the employer to apply any plan exclusions or restrictions that would otherwise be inapplicable if not for the employee's entry into Active service.

Should a Guard and Reserve member elect to continue TRS, or the 180-day post-mobilization (TAMP) coverage after requesting reemployment, these USERRA protections are lifted. Except for that immediate day of re-employment, a Guard and Reserve member may be required to wait a specified period, on until the next open enrollment in order to continue the employer's health care coverage.

2. Servicemembers Civil Relief Act (SCRA)

SCRA (Section 704) also provides Guard and Reserve members with protection of reinstatement of health care insurance without exclusion. The insurance must have been in effect before such service commenced and terminated during the period of military service. An application under this section must be filed not later than 120 days after the date of the termination of or release from military service. Both TAMP and TRS exceed this 120 day period.

3. Pre-existing Conditions: The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

"The length of time coverage can be denied for a preexisting condition under HIPAA is limited to no longer than 12 months (18 months if you are a late enrollee).

This time can be reduced or eliminated if you were covered by previous health insurance (which qualifies under HIPAA as creditable coverage) and if there was not a break in coverage between the plans of 63 days or more."

Should a member takes TRS, and the employer later requires a waiting period to transition back into the employers health care plan, a break of 63 days or longer would jeopardize pre-existing conditions. (See USERRA)

ROA recommends changes to USERRA and SCRA to grant eligibility to employer and private insurance following TRS coverage.

Continuum of Service

Several issues have emerged that should be watched.

Length of orders: The Reserve components are notorious at producing types of orders or by adjusting an order's number of days to reduce cost. For example, a set of 179 day orders would limit a Guard and Reserve member to just one year because TRS is earned in 90 day segments.

ROA Recommends prorating this benefit to allow partial years to be earned.

Any break in Select Reserve status invalidates the health care, but maintains the obligation. Should a Reserve component fail to implement the Service Agreement in a timely manner, the TRS could be forfeited. Many Select Reserve billet assignments are scheduled around a fiscal year.

The Service Agreement as an Obligation

The TRS Service agreement should be viewed as a legal contract between the Guard and Reserve member and his or her Reserve component. Both sides are obligated to fulfill this contract, but there is some question as to when these obligations become binding.

If a Guard and Reserve member chooses to cancel their TRICARE Reserve Select coverage, it does not eliminate their remaining obligation to serve for the duration of that contract. Similarly, if a Reserve component member is removed from a Selected Reserve billet, the government could be legally challenged. Uncertain is when these obligations begin.

The Guard and Reserve member is by law required to apply for TRS before he or she is demobilized. The Final Service agreement must be signed 30 days before the end of TAMP. DOD has taken the position that Select Reserve obligation is binding from the first application. In contract law, a contract arises when an offer to make a contract is accepted. When the Guard and Reserve member's application is completed at the demobilization site, it is just an extended offer. This website even includes a disclaimer that a Select Reserve billet assignment is not necessarily available.

The definition of a contract includes a promise to do something in exchange for money or goods, or a promise to do something in exchange for a promise to do something. Until the Reserve components can promise something in return for the offer of duty obligation, no contract exists. These promises becoming binding only when both parties sign the service agreement.

Additionally, no contract is binding if it is signed under duress. Demobilization is a very stressful period, where Guard and Reserve members are not focusing on details, but are looking at getting home. The early application as required by law can't be viewed as a binding obligation.

ROA recommends that the law be changed so that the Service Agreement is signed by both parties 120 days after demobilization rather than at demobilization.

Retention Tool or Benefit?

It has been suggested that this new TRICARE for reservists will encourage retention and longevity. Knowing that it takes a tour of duty to qualify, reservists should be eager to serve once ever 6 years. This provides the predictability and periodicity that DOD feels is needed by both reservists and their civilian employers.

An opposing view is that rather than retaining reservists, the new benefit will cause them to leave the Reserves. Both new health and education benefits are based on the ability to deploy. A year on, 4½ year off rotation will place stress on both family and civilian employment. To keep needed benefits, a reservist will either have to focus on his/her civilian or Reserve career path. Pressures may preclude doing both.

Retention Concern

As a Retention tool, not everyone is included. The Army, the Marine Corps, and the Navy have mobilized reservists out of the Individual Ready Reserve. Under current law, unless these Reserve component members are given an opportunity to join the Selected Reserve, they are not eligible to purchase TRS.

All Services offer drilling for points without pay. These members are in the IRR. The Navy has Voluntary Training Units. The Air Force and Army have non-paid Individual Mobilization Augmentees (IMA). The Army also has a group within the IRR body that has agreed to mobilization during their first 2 years.

ROA feels that IRR members should be eligible for TRS. They could qualify if they sign an agreement of continued service and complete a satisfactory year of training and satisfy physical standards. A satisfactory year could be defined either by points or by training requirements, as defined by each Reserve Chief.

ROA recommends at a minimum the laws language be changed from "Selected reservists" to "Drilling reservists".

When Congress created TRS, ROA views it also created an earned benefit. By going to war, you should be eligible for health care benefits without obligation. One group, recalled reservists who are in Gray area retirement, will never qualify for

TRS, as normally they are not eligible by policy or law to return to a drill status. TRICARE Reserve Select should be likened to a GI Bill entitlement rather than a retention tool.

Cost Limitations

ROA recognizes the fact that there are cost prohibitions with DOD subsidizing a blanket TRICARE health plan for reservists.

ROA encourages Congress to explore options to expand payment sources should the new premium based TRICARE Standard program be expanded to a wider Reserve population.

As suggested this past year by the Senate, drilling reservists could be given an opportunity for an employer or other benefactor to buy-in to TRICARE at 72 percent of premium cost, rather than being paid by DOD.

Additionally, gray-area reservists should be permitted a chance to buy-in to the same plan, paying full premium costs. Further, funding needs to be explored on how to help the unemployed and uninsured reservist.

With innovative approaches Congress can provide reservists with continuous health care to optimize medical readiness and insure recruiting and retention.

Reserve Officer Association feels that it is inappropriate that drilling guardsmen and reservists are the only part-time Federal employee not entitled to a health care plan. ROA supports a continuum of health care from joining the Reserves up to retirement.

The hearing is adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR SAXBY CHAMBLISS

HEALTH CARE FUNDING

1. Senator CHAMBLISS. Dr. Chu and Dr. Winkenwerder, there is some concern that funding for medical care for our military personnel and their families, whether Active, Reserve, or retired, is increasingly competing for funding against other Department of Defense (DOD) programs. Some have questioned whether providing health care to our retired servicemembers has any positive effect on recruiting and retention. Others have argued convincingly that having a first-class health plan for retirees is a crucial selling point for recruiting and retaining soldiers. Senator Warner has been recently quoted as saying that "There's no sense in buying modern weapons, unless you have healthy, intelligent people who can operate them and are willing to stay there."

There is much anecdotal evidence that health care benefits are highly valued by military personnel from new recruits to career personnel. What would be valuable to know is whether any studies have been undertaken to quantify to what extent there is a link between health care benefits and recruiting and retention. Has the DOD conducted any surveys of military personnel to determine to what extent health care benefits, for both those serving and after retirement, motivate servicemembers to join the military in the first place and reenlist for more service, and then stay until retirement and if so what effect do health care benefits have on recruitment and retention?

Dr. CHU and Dr. WINKENWERDER. If a servicemember is provided a non-cash or in-kind benefit like health care, clearly the individual will be better off than before. This makes the military more attractive to potential recruits and induces some members to stay longer than they otherwise would. However, the issue is not whether some members will stay longer or others will join that would not have otherwise, the issue is what value do members place on these benefits? In other words, is the provision of health care beyond that necessary for readiness purposes an efficient way of accomplishing an increase in retention and recruitment? Although there are no studies that directly relate recruiting and retention to the provision of health care benefits, there are a number of theoretical and practical reasons to believe that the value of health care benefits to the servicemember, especially those benefits provided to retired members, is less than the cost of providing the service. The basis for this statement is that the benefit is "in-kind" and deferred, that is, provided at some time in the future.

By in-kind benefits we mean specific goods and services, like health care, that are provided to military members rather than cash compensation. While cash compensation offers complete flexibility in purchase decisions, in-kind benefits are tied to a specific good and, consequently, are of little or no value to the member if he or she does not use that service. Also, in-kind benefits are generally not tailored to the

preferences of an individual servicemember and thus it is likely that family health care will not be valued or valued at a substantial discount by single members, by members that do not use health care services, and by members whose spouses have health care insurance from the spouse's employer. Because the service is not valued by some members, there is a wedge between the cost to the government of providing this service and the value that at least some of these members place on the service. Given the choice of "x amount of dollars" in health care or "x amount of dollars" in basic pay, many members would opt for the cash since the value to them of health care is less than the cash alternative; the larger the wedge the greater, the inefficiency. (See Deborah Clay-Mendez, Cash and In-Kind Compensation policies for a Volunteer Force: The U.S. Experience, June 2004.)

The present value to the servicemember of compensation that is received at some future date must be discounted by the member's rate of time preference. In other words, the value to a member of future benefits is the amount of money that the member will accept today in place of a dollar's worth of benefits to be delivered in the future. There is considerable evidence that servicemembers have a discount rate that is significantly higher than the value the government places on future benefits. According to Warner and Pleeter (*American Economic Review*, March 2001), the discount rate for an average enlisted member is in the range of 17 to 35 percent. If the discount rate were 17 percent, a promise of \$1,000 20 years in the future would only be worth \$47 to the member today. If the discount rate were 35 percent, that same \$1,000 would be worth \$2.47 to the member. If the cost of providing future health care as reflected in the accrual rate for TRICARE for Life is about \$6,500 per Active-Duty member and the discount rate is 17 percent, a 20-year old member who would start receiving these benefits at age 65, would value this benefit at \$5.50. Benefits today are thus preferred to benefits in the future.

In the August 2004, Status of Forces Survey, the Defense Manpower Data Center asked respondents how much more in retired pay the member would accept in lieu of TRICARE for Life. The average response for officers and enlisted was \$3,804 per year only about 60 percent of the value of the service to be received. This is an example of a situation where the value of benefits received is considerably less than the cost of providing the benefit, in which case recruitment and retention would not be as high as the cash equivalent value of the benefit.

LICENSED PROFESSIONAL COUNSELORS

2. Senator CHAMBLISS. Dr. Chu and Dr. Winkenwerder, currently, TRICARE requires that physicians refer clients to and supervise mental health counselors who provide mental health services to its beneficiaries. This requirement is in contrast to TRICARE's policy of providing direct access to clinical social workers and marriage and family therapists. Mental health counselors, also called Licensed Professional Counselors (LPC), are professionals with masters or doctoral degrees in counseling or a related discipline who provide services along a continuum of care from diagnosis and treatment of mental illness to educational and preventative services to long-term care. Clinical training and licensing requirements for mental health counselors are comparable to the training of other master's level TRICARE providers including clinical social workers and marriage and family therapists. The DOD recently received the results of a pilot study that examined whether LPCs should be granted the same treatment that other health providers enjoy. What were the results of this study?

Dr. CHU and Dr. WINKENWERDER. The National Defense Authorization Act for Fiscal Year 2001 directed the Department of Defense to conduct a demonstration project under TRICARE that would allow beneficiaries to access licensed mental health counselors without the requirement for either physician referral or clinical supervision. The demonstration began 1 January 2003 and ended 31 December 2003. The demonstration consisted of a control arm and an experimental arm (access to licensed mental health counselors). The evaluation of the demonstration was focused on a comparison of utilization of services, cost of care, and outcomes. Upon completion of the demonstration, the TRICARE requirement for physician referral was reinstated.

The RAND report "Expanding Access to Mental Health Counselors—Evaluation of the TRICARE Demonstration" showed that with removal of the referral and supervision requirements patients were less likely to see a psychiatrist, and less likely to receive a psychotropic medication to treat their mental illness. There was also an increased frequency of inpatient hospitalization for mental illness in the demonstration area compared to the control area. Therefore, DOD is concerned that increased hospitalization may suggest poorer outpatient control of symptoms, result-

ing in higher, possibly preventable rates of admission. Access to Licensed Mental Health Counselors (LMHCs) practicing independently is more likely to result in substitution of type of provider, rather than increased access to mental health services. Without the requirement for physician referral and supervision, there is significant risk that patients will unwittingly incur out-of-pocket costs for non-medical counseling services that are not covered by TRICARE.

Additionally, Medicare and the Department of Veterans' Affairs (VA) require physician supervision of mental health counselors. DOD is unaware of other health insurance plans that authorize independent practice. A major concern is the lack of national or uniform standards of accreditation relating to educational requirements for obtaining a degree, a lack of agreement in the profession on recognition of a national certification body or exam, and the differences in requirements among the states to obtain a license. We assure quality of care through rigorous requirements for academic and professional credentials, relevant experience and licensure and periodic recertification. For psychiatrists, psychologists, social workers, clinical nurse specialists, and marriage and family counselors, these standards are derived from well-established bodies of accreditation. LMHCs have a wide range of standards, licensure, and certification requirements which makes it difficult to endorse independent practice that will result in comparable high quality mental health care across our system. Given differences among States in curricula, accreditation, and supervised post-graduate practice, the Department has ongoing concerns about the TRICARE program's ability to maintain a uniformly high quality of care across geographic areas.

3. Senator CHAMBLISS. Dr. Chu and Dr. Winkenwerder, what are the DOD's plans to change TRICARE policy in order to provide more streamlined access to mental health care providers particularly when the requirement for mental health care services is expected to increase as a result of combat operations in Iraq and Afghanistan?

Dr. CHU and Dr. WINKENWERDER. Both in our military treatment facilities as well as in our TRICARE network, our beneficiaries have direct access to mental health services. This means they can go directly to see a mental health provider who does not need a referral from a physician to be an authorized provider for up to eight sessions; without the need for a referral from their primary care manager.

We have initiated several changes to improve this basic benefit. Pre-clinical care is now also offered through our DOD-wide work-life program called Military One Source. The One Source program offers up to six free, confidential counseling sessions per person and includes marriage and family counseling, personal problem solving, and everyday life events counseling, which are not TRICARE benefits. If a diagnosable health concern arises that exceeds the scope of the One Source program, the counselor will personally facilitate a referral to a military health system health care provider to ensure continuity of care. While not a health care program, the One Source system increases access to care by offering an easy method for entry, decreases potential misinformation and the perceived stigma that can be associated with mental health care, and increases information and education about mental health care and its benefits.

Special programs facilitate access for servicemembers who have served in operational or combat deployments. First, Pre-deployment Health Assessments provide an opportunity for each servicemember to identify any mental health concerns before deployment. Immediately upon return, our servicemembers receive a Post-Deployment Health Assessment which allows them to identify mental health symptoms or to request a visit with a health care or mental health care provider or family counselor, even if they do not currently have symptoms. In addition, servicemembers receive a medical threat debriefing and benefits briefing which assists them in identifying potential health concerns that may emerge in the future and where to seek care if those concerns present. Once they return to their home station, they participate in a deployment support and education program, which includes a family reunion and reintegration component to assist in facilitating access to health care for family members.

Our newest point on the deployment cycle continuum of care is the Post-Deployment Health Re-Assessment (PDHRA) program. This program is scheduled to begin implementation in June of this year. It will provide a repeat assessment of returning servicemembers at the 3 to 6 month period after their return from an operational deployment along with education and outreach for deployment health concerns, with a specific focus on mental health issues. This global health assessment will also include a mental health assessment and will again provide increased access to mental health care based on reported health concerns or at the request of the individual even if they have no current symptoms or concerns.

In the coming year, DOD will be implementing an annual Periodic Health Assessment (PHA) that will address both physical and mental health conditions for every servicemember, not just those who deploy. This process will assist in identifying mental health concerns and conditions that may be associated with the potentially high stress levels of those who serve in garrison. The PHA will also be available to retirees and to family members.

Over the past 2 years, DOD has implemented several clinical practice guidelines that assist our health care providers in delivering state of the art care for mental health issues. They include the Post-Deployment Health Evaluation and Management Clinical Practice guideline, which is mandated for implementation in all military treatment facilities. Guidelines especially relevant to mental health include major depression, acute stress and post-traumatic stress, substance use disorder, and medically unexplained or ill-defined conditions.

Several initiatives are designed to bring mental health care to the forces rather than waiting for conditions to present in a traditional clinical setting. The Operational Stress Control and Readiness (OSCAR) program in the Marine Corps has embedded mental health providers into line units to provide ready access to preventive stress management resources. The Air Force Behavioral Health Optimization Program embeds behavioral health providers into primary care settings, increasing easy access to care and reducing the potential stigma of seeking care through a traditional mental health clinic.

Finally, for those individuals diagnosed with Post-Traumatic Stress Disorder (PTSD) as a result of combat who are not effectively treated through other clinic settings, we have established a specialized care program. While located at Walter Reed Army Medical Center, the program services the entire military community. It provides intensive rehabilitative care for chronic ill-defined conditions and PTSD through a 3-weekday hospital program.

TRICARE RESERVE SELECT

4. Senator CHAMBLISS. Dr. Chu and Dr. Winkenwerder, TRICARE Reserve Select (TRS) provides our Reserve component personnel with an excellent health insurance option at a relatively low cost. For each 90 day period of consecutive service, Reserve component personnel receive a whole year of TRS coverage. So if a reservist is mobilized for 2 years, he would earn a health care benefit that will last for 8 years as long as he remains in the Selected Reserve. However, if that reservist is mobilized again, say 4 years into his 8th year benefit for a period of 180 days, he would not earn another 2 years of eligibility because his "new" benefit would run concurrently with his "old" benefit. This situation could occur because the law states that the benefit will start the day after the 180-day demobilization coverage ends. As it stands, the language of the law does not seem to encourage volunteerism in our Reserve Forces. What are your thoughts on changing this provision in TRS so that the benefits would run consecutively rather than concurrently?

Dr. CHU and Dr. WINKENWERDER. DOD is implementing the TRICARE Reserve Select program in accordance with the statutory requirements. As noted, a period of accrued TRS eligibility will continue to run even if the TRS coverage is in suspense because the reservist is in another period of Active-Duty service. The member may qualify for another period of TRS benefits based on the additional Active-Duty service, but this would not extend the period of coverage earned in the prior activation. If Congress were to revise the statutory requirements so that earned periods of eligibility run consecutively, this would extend the time period of eligibility for reservists activated more than once. In order to take advantage of the extended time period, reservists would need to commit to continued service in the Selected Reserve.

[Whereupon, at 3:24 p.m., the subcommittee adjourned.]

